the Canadian Nurse

VOLUME 60 • NUMBER 1

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JANUARY 1964

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By CARL C. FRANCIS, A.B., M.D., Associate Professor of Anatomy, Department of Anatomy, Western Reserve University, Cleveland, Ohio. Published January, 1964. 4th edition, 478 pages, 6½"x 9½", with 325 text illustrations and 25 color plates, and a Trans-Vision® Insert of the Human Anatomy illustrated by Ernest W. Beck. About $6.75-$7.00.

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By GLADYS S. BENZ, R.N., M.A., Associate Professor, Pediatric Nursing, State University of Iowa College of Nursing, Iowa City. Ready next month. 5th edition, 547 pages, with 124 figures. Price $7.50

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Between Ourselves

This message is being written in the dying days of one year; you will be reading it in the early days of a new year. This is our opportunity, therefore, to extend to you our greetings and best wishes for the unknown, the uncertain yet challenging days that lie ahead during 1964.

For many of us, personally, the beginning of a new year is a time of reflection, of looking back and peering ahead, of satisfaction and dissatisfaction with the things we have done and those we have left undone. Because of the infinite variety of work and play patterns that can be found among our thousands of members from coast to coast, New Years Day marks a brief pause rather than an ending and a beginning.

As you look ahead into the months to come and figuratively or literally encircle dates on that new calendar, we hope that one of the first rings you will make will be around the dates "June 14-19." Perhaps you should write beside that week "CNA-St. John's." In the meantime, all the best to all of you in this NEW YEAR.

* * *

You will enjoy the "different" New Year message from President E. A. Electa MacLennan. You might like to share it with your non-nurse friends and, particularly, with your patients.

* * *

Speaking of patients, how long is it since you have been one? Did you have a private room where you could, to a considerable degree, maintain the status quo of your more normal life or have you ever shared the fairly restricted existence of those who are in semi-private accommodation?

For a closer look at the personal activities, thoughts and reactions of an individual in a multiple-bed unit, read R. W. RAMSAY'S account of his three and a half weeks in hospital. As a graduate in psychology, Mr. Ramsay had a more penetrating insight into his own and the other men's reaction to hospital life than the majority of patients have. We would be interested to know your reaction to his comments for even among those of us on the editorial staff opinions regarding the validity of some of his comments are divided.

The continuing reports of an inadequate number of qualified nurses to meet the needs and demands of hospitals and all the other health organizations across Canada has raised the same question in many schools of nursing: "Why should we produce graduates to work in other provinces or countries?"

The steady movement of nurses from one position to another, from one province to another, from our country to another, particularly the United States, is not a new thing peculiar to today's generation of nurses. To the best of our recollection, in fact, the only time there has appeared to be a superabundance of nurses was during the severe depression years of the thirties. Even during the war years, when restrictions were imposed upon the exodus of nurses beyond our borders, there were shortages of staff in many areas as nurses moved from Halifax to Victoria with stops at places anywhere and everywhere.

So the answer to the question "Do we lose our graduates?" must be an unequivocal "yes, temporarily." But, we also have gained an amazingly large number of nurses who have received their professional training elsewhere. The real question, therefore, is this: "Is our balance of trade in nursing talent satisfactory?" No serious complaint can be made against this form of export if it is not too out of balance with our imports and the returning flow of our own graduates. Indeed, a healthy interchange of talents is generally regarded as essential in a civilized community.

Early last year, the *American Journal of Nursing* announced to many Canadian hospitals that no more advertisements for staff would be accepted for publication. Our *Journal* was inundated with letters inquiring why we continued to accept advertisements from American hospitals, postgraduate courses, etc. The Journal Board considered this correspondence very carefully. Their conclusion was that since all the members of the Canadian Nurses' Association receive their own journal every month, they have a right to receive information in respect to employment opportunities or postgraduate courses that are

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Caution—Children under 2 years should not be given the expectorant containing codeine.

The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.

(Continued from page 2)

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* * *

Although the Dominion Bureau of Statistics publishes an annual figure of the numbers of nurses leaving Canada, no authentic information is available regarding the number who return home again. Our circulation department has a fair idea based on the daily influx of changes of address. The number is considerable. To those of you who are going away or returning home, may we once again make a plea that your change of address be sent to us at least a month in advance. And *please, include your correct registration number and the province in which you are registered.* That is our only accurate means of changing the address on the right name plate. This is particularly important where members of the Nursing Sisterhoods are concerned.

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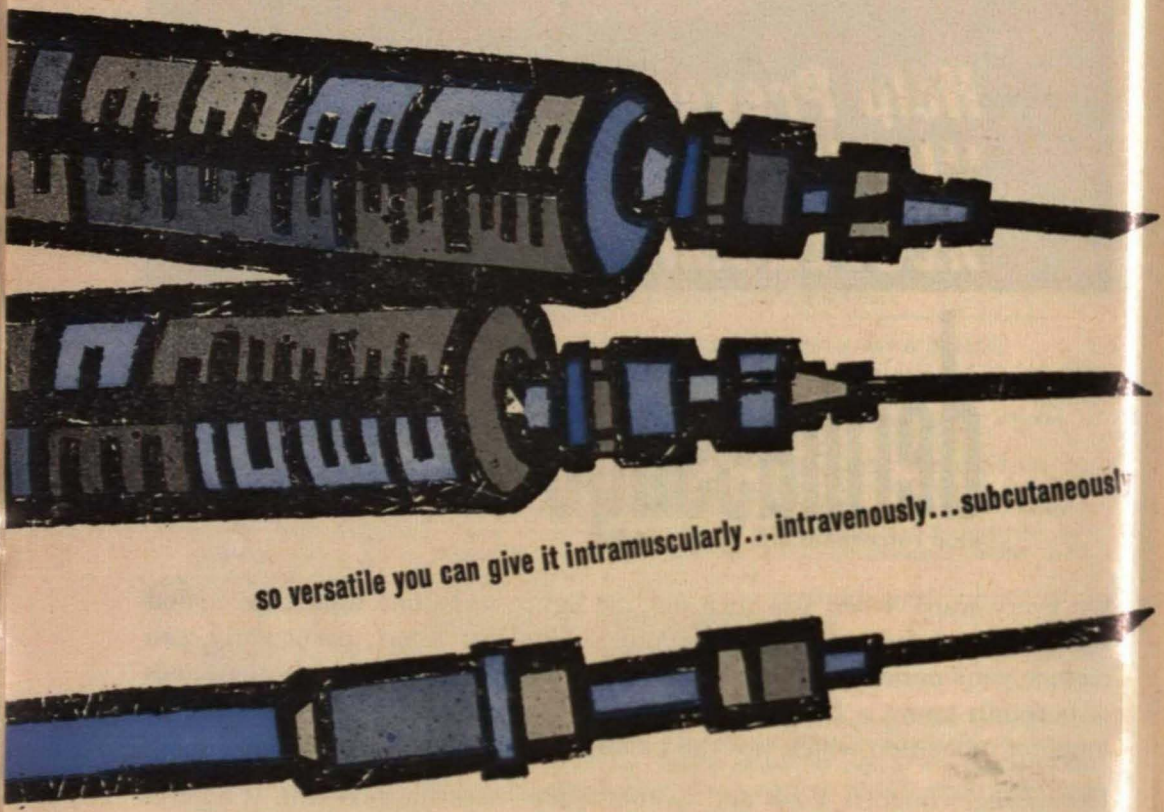

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Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

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References: (1) Ross, S.; Puig, J. R., & Zaremba, E. A.: Antibiotics Annual 5:803, 1958. (2) McCrumb, F. R., Jr.; Snyder, M. J., & Hicken, W. J.: ibid., p. 837. (3) Payne, H. M., & Hackney, R. L., Jr.: ibid., p. 821.

Medical literature available on request.

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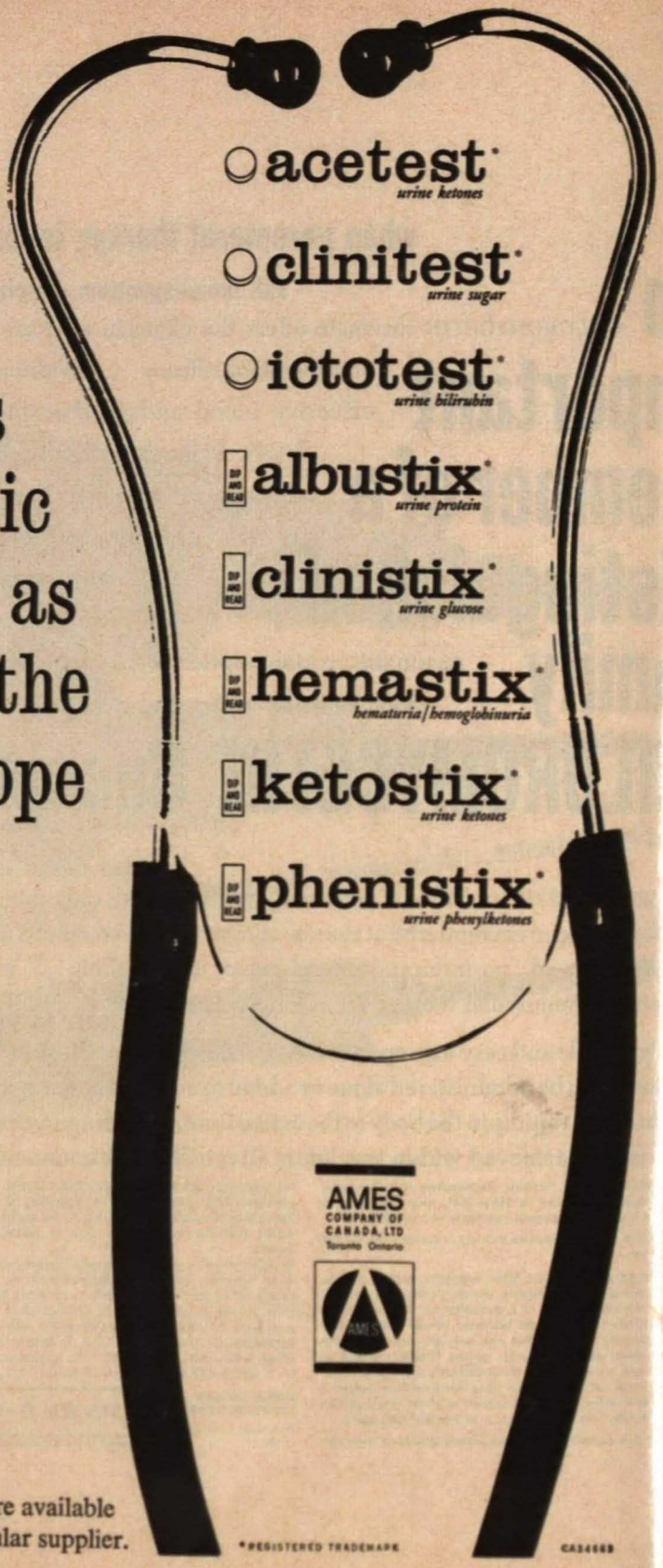

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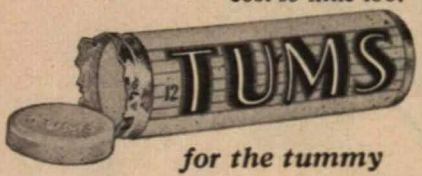

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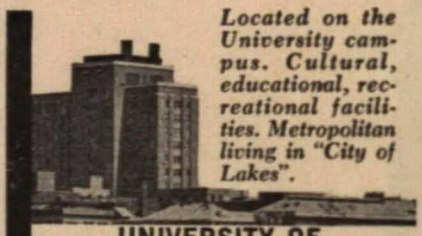

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Random Comments

Dear Editor:

When are schools of nursing going to wake up to the fact that *capping ceremonies* have "gone out of style?"

The CNA recommends that the student nurse be given her cap when she enters the school. Are we so "tradition-bound" that we cannot dispose of this childish ceremony?

I should be interested in comments from others who may or may not agree with me.

R. N., British Columbia.

Dear Editor:

I wish to express my appreciation for the very interesting articles in the September *Journal*.

I was wondering if you could, at some future date, have an article concerning "Intravenous Therapy." Some I. V. solutions are called by code numbers — such as Code 8. It would be interesting to know what they consist of. I am certain that many nurses would appreciate such an article.

GWEN B. TURNBULL, B. C.

Dear Editor:

Journal readers — particularly O. R. nurses — might be interested to learn that the first 1963-64 meeting of O. R. Nurses of Greater Toronto was held October 1 at the Thornhill Division of the Shouldice Hospital. Approximately 100 nurses attended.

Tours of the hospital were given and a display of instruments used for this special technique of herniorrhaphy was exhibited.

After an excellent dinner, the nurses held their regular business meeting. This was followed by a discussion of preoperative medication and the use of local anesthesia by the chief surgeon.

An illustrated talk was then given concerning the technique of herniorrhaphy.

We hope that this meeting will stimulate the interest of all O. R. nurses to join and support their local group.

(MRS.) OLGA D. BRINDLE, Ontario.

Dear Editor:

Have enclosed a few thoughts that I had while making rounds on night duty.

The *Journal* helps keep me abreast of

all areas in nursing. Many thanks for the helpful articles our magazine always carries.

A Hospital Night

Silently the corridor tread,
White shoes near the sick one's bed.
It's night and all the world's asleep.
The sufferer's pains grow sharp and deep.
The nurse who cares and understands,
Caresses the brow with cooling hands.
To comfort a patient is still an art
Of the nursing profession — an integral part.
The age of the atom, cold war and space
Still many dread diseases we all must face.
Are these the thoughts in the patient's mind?
Medical science the answer must find.
Death hovers by ere morning light
Finds nurse and patient have weathered the night.

Marie Landers Brown, *N. B.*

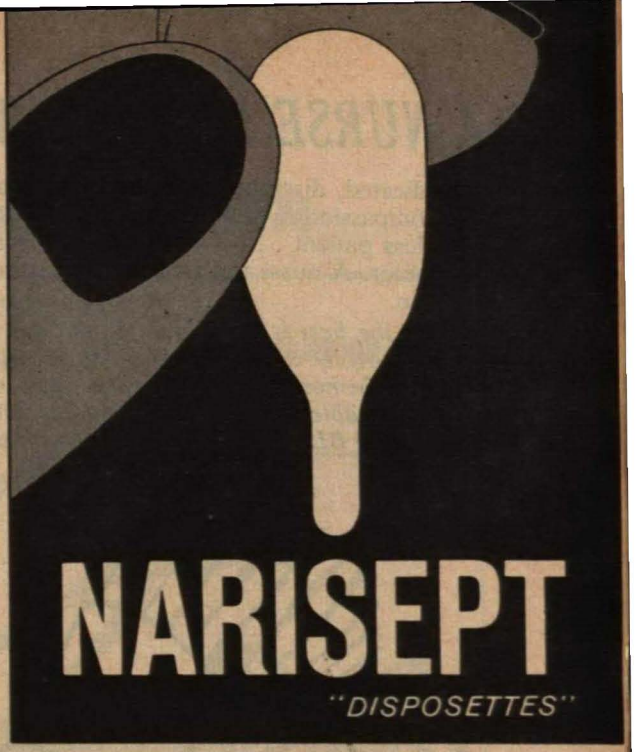
Dear Editor:

May I draw your attention to an item which appeared in the September issue of *The Canadian Nurse*. I refer to the review of the book, "A History of Nursing" from which an extract was quoted stating that since the inception of the National Health Service in the United Kingdom, the General Nursing Councils have less responsibility for inspecting and approving schools, determining standards of practice, preparing the official syllabus, conducting examinations, and the like, but are expected to advise the national ministries now concerned with these problems. The reviewer of the book adds — "This statement allows the reader to visualize the effect that socialized medecine would have on the nursing profession if it should be accepted in Canada."

I would point out that the information contained in the extract quoted from the book is wholly incorrect. The responsibilities of the General Nursing Councils have in no way been affected by the introduction of the National Health Service in the United Kingdom; they are still required to inspect and approve schools, to determine standards of practice, to prepare the official syllabuses, and to conduct examinations.

M. Henry, S. R. N., Registrar,
The General Nursing Council for
England and Wales.

How sickness enlarges the dimensions of a man's self to himself. — Charles Lamb



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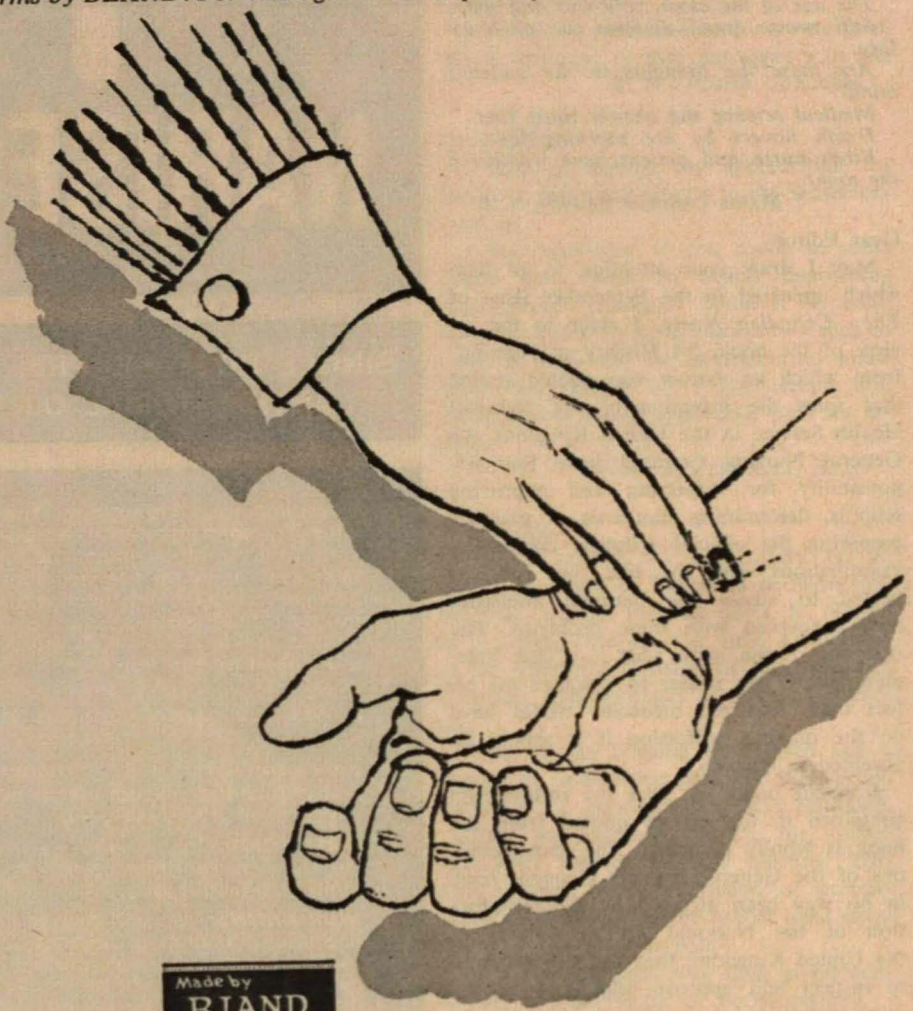

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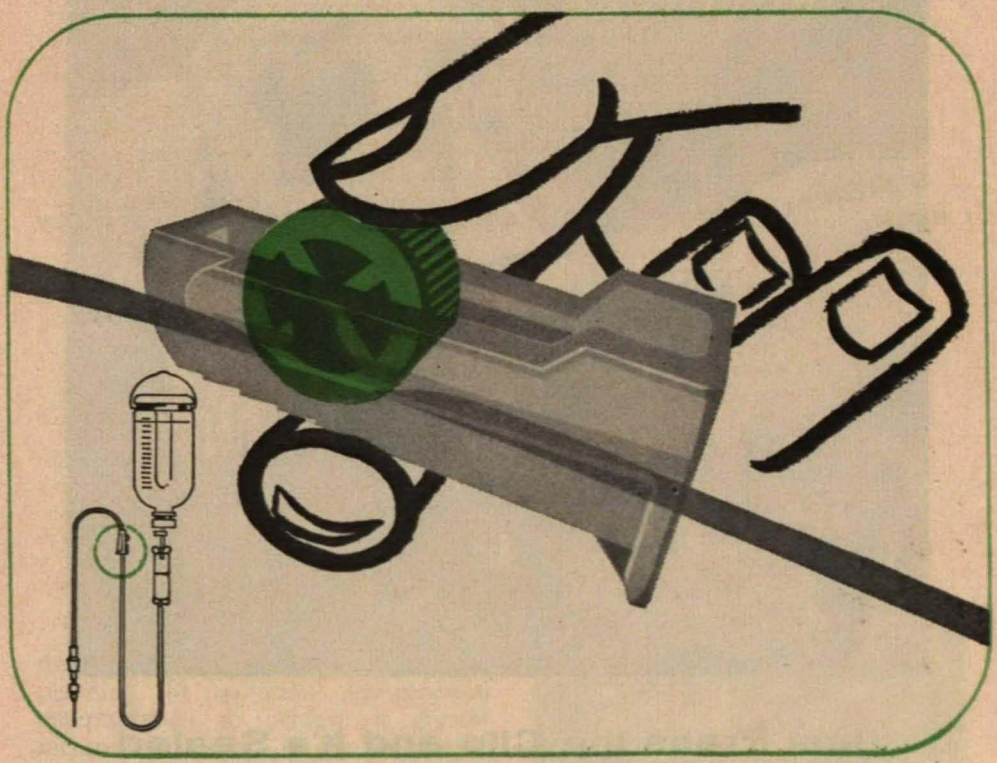

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
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A Sense of Values

The New Year is traditionally a time for looking forward, a time for planning, for resolutions and renewed determination to achieve a greater measure of success in our endeavors.

The New Year is also a time to look back and appraise how far we have come toward achieving those things which we value. I was this far on my draft of this editorial when I said to one of my friends, "What do you look for in a New Year's Editorial?"

"I would hope to find inspiration from the President of my Association," was her reply.

This answer turned my thoughts to an old document I recently discovered and I pass it on to you for your inspiration and contemplation. It is the "Last Will and Testament" of one, Charles Lounsbury of Chicago, believed to have been either an attorney or a once-wealthy real estate operator

(Wright, Halifax)

ELECTA MACLENNAN

who lost all through business reverses, and left the following Will which reveals what wealth of character remained after his material possessions were gone:

LAST WILL AND TESTAMENT

I, Charles Lounsbury, being of sound mind and disposing memory, do hereby make and publish this, my last will and testament, in order as justly as may be to distribute my interest in the world among succeeding men.

"That part of my interest which is known in law and recognized in the sheepbound volumes as my property, being inconsiderable and of no account, I make no disposal of in this my will.

"My right to live, being but a life estate, is not at my disposal, but these things excepted, all else in the world I now proceed to devise and bequeath:

Item: I give to good fathers and mothers, in trust for their children, all good little words of praise and encouragement and all quaint pet names and endearments, and I charge said parents to use them justly and generously, as the needs of their children may require.

Item: I leave to children inclusively, but only for the term of their childhood, all and every, the flowers of the fields and the blossoms of the woods, with the right to play among them freely according to the customs of children, warning them at the same time against thistles and thorns. And I devise to children the banks of the brooks and the golden sands beneath the waters thereof, and the odors of the willows that dip therein and the white clouds that float high over the giant trees. And I leave the children the long, long days to be merry in, in a thousand ways, and the night and the moon and the train of the Milky Way to wonder at, but subject, nevertheless, to the rights hereinafter given to lovers.

Item: I devise to boys jointly all the useful, idle fields and commons where ball may be played; all pleasant waters where one may swim; all snow-clad hills where one may coast; and all streams and ponds where one may fish, or where, when grim winter comes, one may skate; to have and to hold the same for the period of their boyhood. And all meadows with the clover blossoms and butterflies thereof, the woods and their appurtenances, the squirrels and birds, and echoes and strange noises, and all distant places which may be visited, together with the adventures there found, and I give to said boys each his own place at the fireside at night, with all pictures that may be seen in the burning wood, to enjoy without let or hindrance and without any encumbrance of care.

Item: I give and bequeath to girls all beauty and gentleness, and to them I give the crown of purity and innocence which is theirs by right of birth and sex, and also in due season the abiding love of brave and generous husbands, and the divine trust of motherhood.

Item: To young men jointly, I devise and bequeath all boisterous, inspiring sports of rivalry, and I give to them the disdain of weakness and undaunted confidence in their own strength, though they are rude. I give them the power to make lasting friendships and of possessing companions, and to them exclusively I give all merry songs and brave choruses to sing with lusty voices.

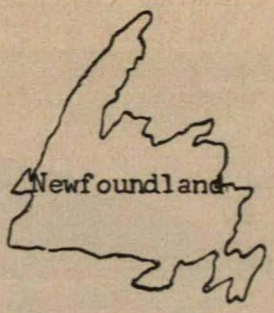
Item: To lovers I devise their imaginary world with whatever they may need as the stars of the sky, the red roses by the wall, the bloom of the hawthorn, the sweet strains of music, and aught else by which they may desire to figure to each other the lastingness and beauty of their love.

Item: And to those who are no longer children or youths or lovers, I leave memory, and I bequeath to them the volumes of the poems of Burns and Shakespeare and of other poets, if there be others, to the end that they may live over the old days again freely and fully, without tithe or diminution.

Item: To our loved ones with snowy crowns I bequeath the happiness of old age, the love and gratitude of their children, until they fall asleep."

E. A. ELECTA MACLENNAN,
President,
Canadian Nurses' Association.

The LORE and LURE of



JEAN E. C. LEWIS

Anno Domini circa 1000! A gaudily decorated *longship,* big enough for a crew of 90, under the command of Leif Ericson, son of the Viking Eric the Red, swept down the barren, forbidding coast of Labrador, according to legend, in search of adventure. Where and how far they travelled has never been authenticated but the rolling woodlands of the island we know as Newfoundland lay athwart their track. Ericson is said to have found the Eskimo inhabitants of that area which he named Markland. Very recent research has proven that their discoveries antedated Columbus by 500 years.

The next explorer to this area was John Cabot, a Genoese navigator in the service of Henry VII of England, who, in 1497, sailed westward from Bristol with his crew of 18 men until his galleon *Matthew* made landfall at Cape Bonavista, the most easterly outpost of the "New Founde Lande". Cabot's reward from his sovereign is noted in the king's Privy Purse account, now in the British Museum. "To hym that found the New Isle £10."

Cabot, though his stay in Newfoundland (New-fund-land) was short, found none of the Eskimos of Ericson's report. Instead, he made contact with a strange race, the Beothucks. Believed to be descendants of North American Indians and Viking seamen, the Beothucks did not welcome the white men. Over the centuries that followed there was constant bloodshed. The last of the Beothucks died in 1829.

When Cabot returned to England he told of waters where "codfish were so thick that a boat could hardly be rowed through them." As the word spread of these rich waters, fishermen from many lands — Englishmen, Frenchmen, Portuguese and Spaniards — set their sails for Newfoundland. Scores of Newfoundland place names reflect the fishing stations they established — English Harbour, Portugal Cove, Turk's Island, Ireland's Eye, Frenchman's Cove.

Alarmed by this invasion of foreign fleets, Elizabeth I sent Sir Humphrey Gilbert, half-brother of Sir Walter Raleigh, to take possession of the island. On August 3, 1583, he sailed into the superb harbor where English fishermen and merchants were building up a small community — St. John's. There he planted the flag of England thus establishing "Britain's oldest colonly." The present War Memorial now

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Miss Lewis who is President of the Association of Registered Nurses of Newfoundland is also the Chairman of the Public Relations Committee of the CNA.

We are indebted to the Canadian National Railways, Dept. of Public Relations, for permission to use the photographs reproduced in this article.

stands on the historic spot.

The first attempt at permanent settlement in Newfoundland was made in 1610 by John Guy, a merchant from Bristol. The site of this "Sea Forest Plantation," as he named it, was at Cupids on Conception Bay.

Petty Harbor, Nfld.

Although John Guy's venture was not completely successful, his example was followed by many other Englishmen. In a very few years a number of colonies had been established along the shores of the Avalon Peninsula, and in 1638 all these were united under Sir David Kirke. Following the failure of this venture, further settlement in Newfoundland was forbidden and from about 1673 until the beginning of the nineteenth century, it was valued chiefly as a fishing station.

During the seventeenth century there was great rivalry between England and France for colonies in the New World. In 1662, the French built a fort at Placentia, in Placentia Bay, and planned to occupy the whole island. For many years they threatened English supremacy in the island and, indeed, on two occasions captured St. John's, the capital. Hostilities between the two countries were ended by the Treaty of Utrecht in 1713 and sovereignty of Newfoundland was secured to England. Certain rights for catching and drying fish on the Island were reserved to French subjects. These rights were the cause of controversy for nearly 200 years. The two small islands of St. Pierre and Miquelon, sixteen miles off the south shore, were returned to France in 1763 and have always remained in French possession.

During its early period, Newfoundland was governed by the "Fishing Admirals," the masters of the first fishing vessels to arrive each spring. In 1729, the first Governor was appointed by the British Parliament. For many years there was bitter strife between the Fishing Admirals and the Governors. Finally, however, the authority of the Governors was established and, some three hundred years after its discovery, Newfoundland

Bauline, Nfld.

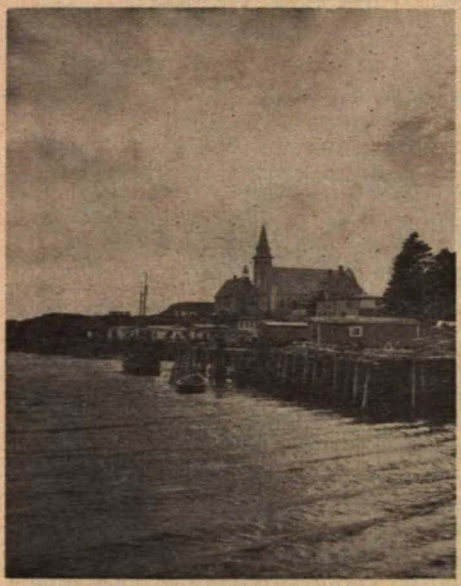
commenced its true development. In 1832 the Island was granted representative government and twenty-three years later became self-governing and enjoyed the political rights that already had been granted the other British possessions in North America.

Responsible government was suspended in 1934 and Newfoundland was placed under a Commission of Government appointed by the British Crown.

During the forties the financial position of Newfoundland greatly improved and the time came when it was considered that the country could again be self-supporting.

In 1947, terms of union with Canada were discussed with representatives of the Canadian Government. Terms of union were signed in December 1948 and, following their ra-

tification, Newfoundland became the tenth province of Canada immediately before midnight on 31st March, 1949.



Placentia Bay

The population of Newfoundland (including Labrador) is approximately 478,000. Most Newfoundlanders are of British descent, chiefly English and Irish. All the towns and settlements, except for the forestry and mining communities, are located along the coast in the many sheltered harbors and coves. Forty-five per cent of the population lives in the Avalon Peninsula at the south-eastern corner of the Island.

Newfoundland is rich in natural resources. The sea supports its main industry — fisheries. The forests pro-

Conception Harbor

vide pulpwood for two big pulp and paper mills. Around the Island's producing mines thriving towns have grown up.

A well known journalist in Newfoundland Mr. A. B. Perlin writes "With good communications and some partnership in resource development, Newfoundland can attain a measure of economic security that will otherwise be beyond her grasp. Above all she needs the sympathetic understanding of the rest of Canada as she seeks to play a fuller part as a member of the Canadian Federation."

EVER SEE A WHALE ?

Here's your chance. There are all sorts of Atlantic ocean fishing trips and cruises lined up for the nurses attending the CNA convention at St. John's, Newfoundland, June 14-19, 1964. You *are* coming, aren't you?

P.S.—Bring slacks. You'll need them to fight the fish.

Observations of a Ward Patient

R. W. RAMSAY, B.A., T.D.

This is a sociological view of a 1,200-bed general hospital as seen from one room containing four beds for male patients. These observations were made over a three and a half week period while I occupied one of these beds. It is a narrow and biased view but it is, nevertheless the only one that a patient sees.

The staff of a hospital moves in the large world of the whole institution, the residence and their off-duty private life; the patient is confined to one room and has to make the most of his restricted world. Little things become very important. A bed with a view of the corridor is prized more than a bed next to the window because the former keeps a patient informed of the activity within the hospital. A window provides a view of the outside world which has ceased to exist for him and no longer holds any interest. One patient when told by a staff member that it was raining, said in a bored voice, "Oh, I haven't looked out for a few days."

Hoarding

It has been observed in animal laboratories that rats, deprived of food for any length of time, when given plenty of it will hoard it and other available articles in their cages. Patients do the same thing. They are well fed but since they are deprived of the usual luxuries, they will hoard all sorts of articles which, to the staff, appear ridiculous. One patient who had been in the same bed in the same room for 16 weeks, had 5 flashlights, 19 dead batteries, and a pile of empty candy boxes. He stole pieces of string at every opportunity, and almost drove the nurses to despair by refusing to part with any of his possessions. Another patient ordered sugar cubes with each meal even though he never used any. He was saving them for a friend who owned a horse. At last count he had over 90 cubes, the cost of which would probably be about 25 cents. A nurse, taking inventory in lockers and removing excess equipment, finished up with a trolley piled high with rolls of toilet paper. There was always plenty of tissue provided but some patients had accumulated four rolls. The nurse may complain about this but it is a reaction to an environment lacking the usual amenities of life.

Overt and Covert Roles

When a person enters a hospital he assumes the overt role of a patient, but with this goes the covert role of a helpless child. One of the covert roles of the staff is parental omnipotence. The patient is expected to adopt the role of the child while the doctor is the father figure and the nurses, mother figures. Problems arise, though, as to the extent of these roles. A patient is encouraged to regress to a childlike level: his bed is made for him; he is washed, fed regularly, and catered to, even to the extent of regular back-rubs with baby powder. As in the case of all regression, there is a lack of integration at the lower level of behavior.

Behavior becomes childish. The patient loses interest in the outside world; reading habits degenerate to magazines and comics; small acts become very

Mr. Ramsay was a graduate student in psychology, University of Alberta, Edmonton, when he wrote this article.

funny or very annoying; relationships with the staff consist of ill-concealed bids for attention. Our ward spent many happy hours making and flying paper aeroplanes around the room. The staff is no help in the search for a new role. They are not sure of the limit to which regressive behavior should be encouraged; they want to feel needed and, in some respects, they resent any attempt on the part of the patient to do things for himself. If the patient checks his own temperature, he is accused of cheating; if he takes his own pulse, his count is ignored; childish behavior is looked upon with maternal indulgence.

The ward I occupied was for those with broken bones. Once the bones were set it was a matter of waiting in the hospital until the injuries healed. The patients were handicapped and bored rather than sick. This presents major problems. The doctors' orders concerning his well-being and the general rules and regulations of the hospital are not viewed by a patient as being for his own good. Because of boredom and regressive behavior, he regards these orders as a restriction of his fun. Thus, there is a covert feud between patients and staff. A patient, allowed to go to the phone on a stretcher, will stay out for hours pushing himself around the corridors; then he feels annoyed when the stretcher privilege is withdrawn. A patient allowed up for one hour a day in a wheelchair will go to extreme lengths to confuse the staff about time and extend his one hour to three. Orders are seldom disobeyed but are bent and stretched beyond reasonable limits.

Confinement to bed and helplessness produces, among other effects, a feeling of frustration at not being able to do little things usually taken for granted. Cigarettes dropped on the floor have to stay there until a nurse picks them up. A water tap a few feet from the bed is useless when the water jug is empty. One patient who had polio and could only move around in a wheel chair, found a "drive-in" toilet on the top floor of the hospital but when a wheel chair was not available, he had to wait or suffer the indignity of a bedpan. For one whole day he was without the use of a wheel chair and his frustration was pathetic. Frustration is blocking or thwarting the attainment of a goal. There are three ways of dealing with such a situation:

One can attack the problem directly. This is usually the best method but in the case of the polio patient he could not obtain a wheel chair because none was available.

Another method is to withdraw from the situation and deny that the goal was desired. This behavior has been observed in chronically frustrated laboratory animals and results in neurotic-like behavior.

The third and most usual way of dealing with frustration is to indulge in substitute behavior. This was what happened in the case of the patient without a wheel chair. In keeping with his regression, he had a temper tantrum. Books were torn up; paper was thrown around the room; he pounded his fists into his pillows in a pitiful burst of aggression that lacked an object.

Aggressive Behavior

Aggression and anger are the usual responses to any frustrating situation, and nurses see quite a bit of this. Our room, by the end of a day, looked like a battlefield, the floor littered with the debris of torn paper, sugar cubes, broken pencils, and sundry other objects. The cleaning woman stoically swept out mountainous piles of garbage every morning.

Nurses are frequently targets for displaced aggression. Patients who are frustrated seldom can attack the source of their frustration directly, so they seek some substitute object. Nurses are ideal targets since they usually have to enforce restrictive orders. Consequently, they frequently have to deal with outbursts of anger directed against them. In a male ward the language used to describe the nurses is sometimes abusive and often the nurses cannot help but overhear these invectives. It is important for their mental health and continued efficiency that they recognize this aggression as a product of the patients' situation, not something that is directed against them personally. If they take it personally, their attrition rate rises steeply and unnecessarily.

These outbursts of aggression could be strongly discouraged by the staff, but it is probably better for them to

be maternally indulgent. Psychoanalytic theory holds that aggression deprived of external expression, is turned inward in the form of depression, which is a serious handicap to the speedy recovery of the patient. A burst of aggression is cathartic and relieves tensions. If it is not taken personally by the staff, it does no harm to anyone and usually does the patient much good.

The "Naughty Patient"

I was told by the other patients when I first arrived that the only way to get anything was to pester the nurses until they tired and assented to the request. This was not quite true because the nurses seemed to be sufficiently hardened to saying "no" to all requests. What it did achieve, which neither nurses nor patients seemed to realize, was increased attention for the patient who was most demanding.

Skinner has postulated attention as being one of the five basic social needs of humans and, in the hospital setting, this social need is great. Patients will go to extreme lengths to obtain attention: Throwing things on the floor for the nurses to pick up; throwing glasses at each other until a nurse comes in to stop them; having water fights across the room; not eating meals; trying to engage the nurse in all manner of verbal banter. The nurses behave in a stern, maternal way and naively play into the patients' hands by responding to these bids for attention.

It is a well-known principle in the psychology of learning that behavior that is rewarded tends to be repeated. The childish bids of the patients for attention are rewarded by the nurses giving plenty of attention to those patients who are "naughty." The "naughty" behavior is, therefore, repeated. If nurses really want to suppress such behavior they should give attention and reward to those patients who cause no trouble, and ignore the troublesome ones. In this way, "naughty" behavior would decrease and "good" behavior would be reinforced. This is difficult to do since it seems to be against common sense. One wonders to what extent nurses are made to feel needed by the naughty behavior. If a patient is "good," has no requests, and is apparently self-sufficient, the nurses may not feel needed and may then wonder if the patient is really sick.

Patient Relationships

As in all institutions or situations where strangers are thrown together, there is a superficial camaraderie and cooperation between patients. Those in wheel chairs visit around, do incidental shopping in the canteen, carry messages for those who cannot move. The usual social strata of money, position or age do not exist because anyone who holds himself aloof from the other patients is ignored until he becomes so bored that he welcomes any overture of friendship. There is an avid interest among teenagers concerning new arrivals, their ages and first names. The vital statistics of the new patient do not remain unknown for more than a few minutes. Little "shipboard romances" develop; the girls cry when they go home; addresses are exchanged; occasionally an ex-patient will write back and say how much he misses the old gang. But these friendships usually fizzle out soon after the patient is discharged and moves once more into the increased stimulation of the outside. Vows of frequent visits and eternal friendships are soon forgotten.

The Doctor

Doctors foster the concept of paternal omnipotence. Orders concerning the welfare of a patient are given in a firm and authoritative manner to the nurse-in-charge, who is usually found trailing obediently behind. The patient has to entrust his bodily well-being to his doctor and, since faith in a treatment is half the battle towards a cure, as shown by reaction to a placebo, the doctor is forced into this role.

He is brisk and confident in his dealings with both staff and patient in spite of the fact that at times he must be in doubt. He is expected to know everything. His words, written down by the charge nurse, become law. He will never hesitate nor admit that he does not know the answer to a question; he will either ignore it or counter with another. If he admitted to ignorance, the concept of omnipotence

would be shattered. When I asked my doctor to estimate the date when I might leave hospital, his reply was "When is your birthday?" Since the patient is so dependent on the doctor, he can only smile, and then take out his hostility on the nurses.

One interesting defence mechanism used by doctors on rounds is "tunnel vision." A doctor walking through a ward to see a patient sees only that patient and nobody else. All patients look up expectantly when the doctor walks in; they follow him closely with their eyes as he walks by. If the doctor looked at each person, he would be forced to greet everyone and ask how they felt. His rounds would take up his whole day. As a defence against this, doctors never see patients to whom they do not want to talk.

The patients take an avid interest in their doctors. Patients in wheel chairs keep the others informed as to the whereabouts of the doctors on rounds. The P.A. system lets everyone know which doctors are on duty. The grapevine is almost as good as in a prison.

Results of Confinement

This interest in the doctors is only one side of the coin of ambivalent love and hate that patients feel towards their doctors. As a healer the doctor is loved and revered, but he is also the person who admits and holds the patients in the hospital. A criminal often does not blame himself for a period of incarceration, but will blame the judge who sentenced him. The doctor has to shoulder a similar displaced aggression from the patient. The doctor is instrumental in the patient's incarceration for an indefinite sentence in the hospital.

There are many similarities between hospital and prison in the curtailment of privileges. There is enforced confinement in a limited space; lack of privacy; inability to choose one's company; lack of sexual outlets. In a hospital there is no lack of sexual stimulation. A backrub is thinly disguised sensual stimulation, but there is little opportunity to satisfy the aroused drive. When normal sexual outlets are denied, substitute behavior is usually indulged in. For the majority of patients, the lack of outlets has to be endured; the frustration and aggression that results is directed to some extent against the doctors who are "responsible" for the hospitalization. The ambivalence manifests itself in the patients' passive dependency on the doctor, their discussions concerning their doctor's merits, their interest in him generally. In the next breath they will rail at the doctor's stupidity, his incompetence and the sadistically restrictive orders he issues.

Who's on duty?

There is also great interest in who among nursing staff are on duty. Each nurse reacts differently and patients soon learn to hold over requests until a certain nurse comes on duty, if she is known to be more lenient. Nurses, being individuals, vary in their feelings of security. Some are secure enough to allow the patients small dispensations while others feel so insecure that they abide strictly by the doctors' orders and refuse to vary them, even in the most reasonable way. One nurse will allow a patient to have a bath in the tub at any time, while another will refuse on the grounds that the doctor has not written a specific order. It is infuriating to want a bath, to know that the doctor approves but because he has not written it as an order, not be allowed to have it. It took me from 7:30 a.m. till 1:30 p.m. one day to get permission for a bath because the charge nurse would not authorize it, nor would she come to discuss it. This was petty on my part but small things become very important when one is lying in bed day after day. This same charge nurse, when asked if I could lie on a stretcher on the sundeck, said she would think about it. By ten o'clock that night she still had not thought.

This behavior on the part of the nurses comes close to what has been called "petty paranoia" in which the original aim of the well-being of the patients is obscured by the aim of running an "efficient" ward according to the letter of the law. This is characteristic of all organizations, including the absurd example quoted by one authority in which a grocer grew to hate customers because they disturbed

the attracive piles of canned goods he built up.

In a prison, an inmate loses his name and becomes a number. In a hospital the patient is depersonalized and becomes a "case." Doctors are usually guiltier of this than nurses. The doctor will often discuss a patient's foot without any reference to the fact that there is a person attached. A nurse, pausing at the door, asked, "Anybody in here?" When one patient answered, the nurse replied impatiently, "Oh, I mean nurse-wise." This depersonalization is not extreme but it is an unnecessary addition to indignities in general.

A "Pecking" Order

Chickens have been observed to develop a "pecking order" in which the most dominant will peck all others, the second most dominant will peck those less dominant but not above, and so on. The same thing has been observed in prisons, mental hospitals and wherever people are thrown together for any length of time. A hospital ward is no exception. A newcomer to a ward moves into an established group with an established "pecking" order and for the first day or two feels his way into the group. He soon finds his place in the hierarchy and seems more comfortable, with a resultant lowering of tension throughout the ward. There is a rise of tension as a patient prepares to leave because the status quo will be disrupted and the next patient is an unknown quantity.

Privacy and Space

Much has been written on the necessity of a certain minimum amount of space needed by animals both in their natural habitat and in zoos. Without enough space, animals will sicken and die regardless of the food supply. The same necessity has been observed in humans in prisons, ships and mental institutions. It has been found that people kept in close proximity to each other find it necessary to pick out some area where they can get away from other people, or to feel that there is some place they can regard as their own. The same needs apply in a general hospital but difficulties arise when patients are bedridden. It is most important, therefore, that the curtains around a bed be closed at certain times of the day. When a nurse forgets to do this, it is difficult for the patient to request it because then it would look like an insult to the other patients in the room. It is most important, especially when bathing, that the patients should be given the privilege of some privacy.

The use of what Goffman calls "group space" can be seen in a general hospital. A number of patients in one room regard this room as *theirs* and resent, to some extent, any intrusion of that space by other patients. One would expect patients to visit around the various wards and find friends in other rooms. This seldom happens, probably because a patient visiting in another ward is intruding on the group space of that ward, is infiltrating the in-group, and is not made to feel welcome. A female patient from a nearby ward who seemed to enjoy visiting in our room met with a surprisingly hostile reception every time she came in; two men who occasionally came in found that no one was willing to talk to them. In fact, conversation dropped to almost nothing while they were in the room but then picked up again after they left.

To Help or Not to Help

One of the features that distinguishes humans from other animals is the adaptability of the former. This is amazingly evident in a ward of people who are incapacitated or handicapped in various ways. One patient whose legs were useless to him as a result of congenital scoliosis, developed the ability to walk on crutches without having to put his feet on the floor. A bar across the top of his bed and a hooked stick extended his reach well beyond the range of his bed; his wheel chair became a highly manoeuvrable machine for exploring every inch of the hospital.

Cooperation between patients extends the range and ability of all patients and makes hospital life much easier. For someone confined to bed, I was surprisingly mobile on a stretcher tied tractor-trailer style behind a patient in a wheel chair, and was able

to go to the phone or up to the sundeck. I found it easy to accept help from another handicapped patient when there was something I could not do for myself but I felt very hostile towards a visitor who insisted on pouring a glass of water which I was quite capable of managing.

Before becoming a patient, I was never sure if I should help the handicapped person. If I helped him he might be annoyed that I could do something that he could not do but if I did not help him, he might regard me as insensitive to his needs. As a result of my own experience, I would now do nothing for a handicapped person unless he asked me to do it. There are numerous little tasks that a handicapped person might take longer over than a healthy person, but he *can* do them and he expects to be allowed to do them. If there is something he cannot do, he will ask for it and not feel in the least embarrassed by asking. This, however, must be taken as the expression of my own personal conviction.

There is little or no concern about the various disabilities among the patients. They are seldom talked about, and when they are it is without any of the embarrassment usually felt by healthy people in the presence of the sick. One patient with congenital scoliosis had been deformed from birth, had undergone so many operations he had loss count, had spent large periods of his life in hospital yet he stated one day, in all seriousness, that he had never been sick in his life and had never spent any time in hospital for illness!

Behavioral Changes

Most patients only stay a short period in a general hospital so that there is not the problem of "disculturation," but the changes in behavior due to institutionalization can be observed even after a few days. There is regression to an earlier form of behavior; reading habits deteriorate; there is a loss of interest in the outside world. There are many other indications of adaptation to the restricted culture of the hospital and the subsequent loss of more complex social skills. Conversation with visitors is superficial and strained. There is often an effort by a patient with visitors to bring the other chaps into a conversation in order to relieve himself of the strain of holding a conversation singlehanded. I was aware of the effort required to talk to visitors and the sense of relief when they left. There was a definite pull toward identifying completely with the other patients and hospital life and avoiding the effort of lengthy, complicated conversations with outsiders.

There is a strong tendency to give up doing any constructive work and settle down to doing almost nothing. Being introverted, I found it easy to lie in bed daydreaming all day; it took an effort to get any work done. One university student, with exams to write soon after he left the hospital, did not do a single minute of studying during his week in bed. One patient who had been in the hospital, on and off for most of his life, behaved most of the time as if he had a low level of intelligence — but he was consulted by the nurses and orderlies on how to construct various complicated pieces of hospital equipment, and he could tell the staff exactly where special equipment could be found in the hospital. He had adapted so completely to the hospital milieu that he would have had difficulty living on the outside. Most patients want to leave the hospital as quickly as possible, but when the time comes for discharge, many express some regrets about leaving the sheltered atmosphere.

Entertainment

Military personnel stationed in isolated places will create their own forms of amusement if there are none of the usual outlets off the station. Patients on a ward are forced into devising entertainment for themselves to fill in the evenings. The days are fairly busy with people coming and going, mealtimes, doctors' visits, baths, etc., but after visiting hours, when the hospital settles down, there is a long empty period until lights out, especially since less sleep is required because of physical inactivity. This is the period when small ward parties develop. Then well-used jokes are told again; horseplay is engaged in to the limits and beyond; cakes, pies and other delicacies brought

by visitors are produced; chicken is ordered from the local delivery service, and occasionally, when an ex-patient is cooperative or someone has been out on a pass, a bottle of liquor is passed around. The latter is a dangerous practice since it is strictly against hospital regulations but it happens and it helps to ease a long, empty Saturday evening. The parties, by outside standards, would hardly be classified as riotous but they are the best available to the patients and are enjoyed as much as more elaborate affairs outside. The enjoyment is proportional to the level of deprivation of the patients. When the alternative is hours of boredom, the parties are forced, furiously jolly, and thoroughly enjoyed.

Conclusion

Much of this account has been focused on the negative aspects of life in hospital, especially with regard to the staff, because these aspects are the ones most easily noticed. The staff generally do an excellent job of looking after the patients. Food is good and attractively served, and backrubs given by capable hands do much towards making life in the hospital quite bearable, if not downright enjoyable. Morale of the nurses is high and this is transmitted to the patients in an infectious manner so that where one would expect depression, there is a cheerfulness and buoyancy that is heartening to witness.

Beware

The Canadian Association of Consumers has cautioned its members about the extreme danger of a mixture of household chemicals which results in deadly chlorine gas being released.

Household bleach, sold under various trade names, is a solution of sodium hypochlorite. If any cleaning substance or acid is added, it will release poisonous chlorine gas. Recently two cases were reported where housewives were using a well-known toilet bowl cleaner. Not satisfied with the way the cleaner was working on the stains, each of the ladies added some household bleach and stirred the mixture with a toilet bowl brush. Death came in a few minutes to one of these women. The other, younger, survived but needed a long period of hospitalization and treatment.

This could happen to you or any member of your family. To be sure that you never combine *cleaner* and *bleach*, keep them stored separately and keep them both away from food storage and medical supply areas. *Vinegar* and other acids will also liberate chlorine gas from bleach. Never let children play with such compounds. They might accidently combine the two to result in tragedy. Read directions on the tin. Sani-Flush is marked poison and warns: "Do not use with chlorine-type bleaches."

When you use a drain cleaner in the kitchen sink, be careful! A Saskatchewan woman suffered painful injury and was fortunate to recover without impaired sight when the contents of a plugged drain, together with the chemical, came up in a miniature geyser. A physician later said that permanent damage to her eyes was averted when her husband washed both eyes with plenty of water. It's wise to keep your face averted, or not directly over the sink, when using a chemical on a plugged drain.

— Saskatchewan *Health Newsletter*

Applicable to Nursing?

Every revolution in scientific thought, whether great or small, reveals that we have not been solving a particular problem properly because of the restricting effect of ideas from the past. Every superstition, every taboo, every incorrect hypothesis or philosophic concept that persists for any length of time, places some limit on human thought. It is from such limits carried over from the past manner of thinking that the mind has to escape to discover new things. Scientific research, like all other creative activity, is essentially an unorthodox business. It depends upon new ways of looking at things which as a rule come to be accepted at first only by part of the population.

—Dr. H. F. Blum, visiting professor of Biology, Princetown University, as quoted in *More for the Mind*, CMHA publication, 1963.

Continuing Education

WILLIAM HAMILTON

This address was presented at an annual meeting of the Saskatchewan Registered Nurses' Association.

"Continuing education," as it is known in Canada, falls into three specific categories:

1. *Up-grading* or *retraining:* This is usually vocational-type training available to the unemployed, or those with lower educational standards to equip them for new job opportunities. Despite half a million unemployed in Canada, there are many jobs available for those who have specialized vocational and technical training.

Vocational training programs and academic evening classes are provided in increasing numbers to facilitate this up-grading. School boards and university extension programs as well as business, labor, and governments are giving leadership and assistance. This "continuing education," is considered to be a grave necessity. The most consistent recommendation from various interest groups at the Canadian Conference on Education in 1962 was for the development of a crash program to provide a competent work force with "built-in mobility" to meet labor market demands. This need, and the complexities involved in meeting it should not be underestimated. Educators and industrial people have said that the kinds of skills provided in school frequently are obsolete by the time the worker gets into the labor market. In spite of this, there is constant pressure to provide more vocational training facilities at the secondary and post-secondary level, often to provide a vehicle for students to get more years of schooling. However, this is only one category of continuing education, and although it is of concern to us, it is not as immediate a problem for nursing as it is in industrial areas.

2. *Professional* and *vocational training:* In some quarters all training beyond the high school level is considered continuing education including training in the professions.Obviously, this kind of education has certain specific functions to fulfill. It might properly be referred to as "higher education" since it has both vocational and liberal educational requirements.

3. *Individual development* and *citizenship:* The third general category is purely voluntary self-development. This is what we normally consider continuing education. It involves educational activity to improve our understanding of our roles as citizens; to increase our knowledge about the economic and social environment and our responsibilities in it; to study human relationships, democratic processes, culture, art, literature, and so on. It is this general area of voluntary continuing education that is most difficult to serve, and around which most writing and study has been conducted.

The terms "continuing education" or "continuing learning" are of recent popular usage, replacing "adult education." This terminology is a reflection of a changed concept. Traditionally, we have thought of education as primarily a part of the growing up period—the formal school system. Additional formal training, either for the vocations or professions has been recognized as higher education. Continuing education is a recognition of the fact that education is a life-long process. It is not something that is picked up at various stages of life in different contexts. For obvious reasons, the term

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seems to be more palatable, and possibly continued use of it will break barriers that have stood in the way of adult education.

The Upsurge

Although professional educators would hardly concede anything more than a nibble, there *is* a rising interest in continuing education. Conferences, workshops, requests for money, for recognition in departmental plans, for professional training for "adult educators" — all of these are signs of a new vocation struggling to become articulate. But why the sudden urge? The answer is simple if we only pause a moment to reflect on what is happening in the world. Man's relationship to his environment — that which gives the satisfactions and securities of life — is changing every day.

We have seen the successful launching of man into space. We may not know all of the technical requirements of such an historic event but certainly we can appreciate the requirements of developing a power unit capable of blasting a delicate capsule beyond the earth's atmosphere, the engineering of a capsule equipped to provide the physical requirements of life at supersonic speeds and where weightlessness exists. The feat displayed precise use of radar and radio meteorological studies — in fact, the application of the physical sciences in their most meticulous detail. The coordination of ground crews, communication crews and so many others bore testimony to man's organizing genius. The preparation of the astronaut — physically and mentally — to carry out such an experiment is expression of the heights that man can reach in technical and emotional schooling. The space age has opened new frontiers to science and given a new image to education.

The newness and complexity of the space age is like a mirror image of the changes that have swept through civilization in the years since World War II. Coupled with rapid technological advance in all walks of life, there has been an awakening of the "sleeping giants" of Africa and Asia. Millions of dark-skinned people now find themselves with new freedoms, new responsibilities, and with the knowledge that the world has the know-how to feed and clothe their starving underprivileged peoples. In reaching to achieve a rightful place in the sun they move with might and not without some hostility to the white races.

The relationship between these technological advances and political changes has been most sharply illustrated in Africa. Exploding nationalisms have overwhelmed some communities, such as the Congo, whose adults are uneducated. Others, such as Ghana, where the adult educational level was considerably higher, have managed to achieve a certain equilibrium.

Add to these revolutionary changes, the fact that the world's population grows at a startling pace. In 1930, the population was two billion. It is expected to double to four billion by the late 1970's. It has been estimated that if the population increase goes on at the same pace, in 30 generations our descendants will each have one square yard of living space.

We cannot fail to be impressed with the amount and speed of change: the rural to urban shift of population; changes in urban living, in home organization, in industry, in working hours, and the rationale of work and leisure time; in the attitude of people towards the responsibilities of the home, the church, and the school.

Against this backdrop of technological advancement, international and local unrest, we consider the needs of education. Man has shown great technical competence but to what purpose if technology only breeds unemployment and human suffering? To what purpose if materialistic conquest is merely the forerunner to moral and spiritual decay? To what purpose if human want and suffering ravage great areas of the world?

Continuing education for self-enrichment and understanding of the environment has become infinitely more important than ever before. New understandings must be created so that new ways may be found for man to manage society, to maintain and improve our level of living and, at the same time, to achieve greater freedoms, security and satisfactions. Automation and science will continue to forge ahead. Educational programs

must develop people not only to use new-found knowledge, but to provide for a society in which they can maintain some self-dignity and make a worthwhile contribution through an extending span of years.

The behavior and attitudes of our society is a reflection on our education, our maturity, our sense of direction. We must learn to accept the world as a community of near neighbors, face up to our problems and find solutions for them. Obviously, the school cannot do the required educational job in the few formative years of life. Continuing education for democratic living and responsible citizenship is imperative. However, the arrangement and conduct of informal continuing educational programs, which attract and satisfy the needs of people in strictly voluntary association, pose many problems.

Principles of Planning and Organization

Since we recognize the need for continuing education, particularly in the field of public and human affairs, programs organized for voluntary groups necessarily reflect these interests. Application of some of the principles of organization implies that organization of activity is of itself an educational process; that participants have to express their needs if the program is to be meaningful to them.

General Principles

1. Program *objectives must be sharply defined,* and must be understood by all participants. Objectives must be attainable in a reasonable length of time.

2. The program must serve the *needs* and *interests* of the group, providing personal satisfaction.

3. To maintain interest and serve needs, the participants must be *involved* as much as possible *in program development and conduct.*

4. The participant must be able to *grasp the significance* of the whole question in relation to his own understanding and experience.

5. *Good educational techniques* are just as essential to adult educational programs as to school programs.

6. The program should be *continually evaluated.*

Clarification of Objectives

Many adult educational programs have been conceived with the best of intentions; have been launched with the maximum of enthusiasm, but have eventually fallen short of the target because of lack of clarity as to what they were expected to achieve. Unless everyone recognizes and shares the purpose and direction, chaos and disillusion are bound to arise.

Sometimes a group organizes to attack a specific problem only to find that the problem has shifted or new situations have developed. Once an over-all objective has been established there must be recognition of the problems that may arise in achieving it. If the program is drawn out over a period of time, the participants must be able to experience periodic achievements.

Needs and Interests

Adult educators are constantly faced with the question "Why don't they come?" When interest is lacking, or when enthusiasm drops off, the question that should be asked is "What *haven't* we done?" Research has established that:

a. Adults learn most rapidly when the learning provides personal satisfaction;

b. satisfaction can only occur when the learning situation really affects the needs or wants of the individual.

To engender enthusiasm for continuing education programs, the director must obviously ascertain the needs and interests of the individuals. To say that if a person voluntarily joins a group, and because she believes in the objectives she should become active, is to overlook a basic human characteristic. People are motivated to join an organization in order to learn or to satisfy some basic need. In voluntary adult programs the motivation to participate or not to participate may be rooted in any of a whole complex of relationships. Considerable research would be required in any given program to ascertain motivation. In institutional programs, however, motivation is more difficult and more delicate. Nonetheless, if an adult educational program is to result in changed behavior, its development should have

some elementary understanding of the determinants of behavior. We recognize that people react to the motivating forces of physical development, personal growth, security, new experience, affection, or recognition — any of which together with experience and ability result in behavior.

A satisfying program must provide experience that will satisfy some of these needs. In other words, while the program objectives may look appealing, each person is looking for a means to satisfy some of her own needs. When the needs are met, interest will wane and some new challenge should be undertaken.

Involvement in Planning

The only way an adult educational program can continue to satisfy its participants is to involve them in its development as much as possible. A high degree of involvement results in satisfaction and stimulus, and, at the same time, provides for growth of the individuals involved. How can this be done in a specific training program?

A definite body of knowledge is needed in order to do a certain job. How can the participants decide what kind of a program is required? Admittedly, the school student cannot plan the curriculum! At the same time, however, the student, by his reactions, will raise questions about the curriculum. At the elementary and secondary school levels we have had considerable soul-searching related to curriculum planning in order to develop programs that will challenge the "gifted" child; of multiple options in order to provide something to satisfy the appetite of every student. As much as anything, these demands have put the spotlight on the need for research to understand better the adaptability of the student. The curriculum for school students as for adult voluntary participants must serve the needs of those individuals or they will withdraw, either in interest, as apparently happens to school students, or physically when attendance is voluntary.

Involvement in Conduct

At some point, the assumption was made that adults learn by being "talked at." How or why this assumption arose is a mystery. There seems little doubt that the principles of good pedagogy apply equally to adults and to school children. This is particularly true when the participants are not well-known to the adult educator or at least when the level of understanding is not previously established. Informal adult educational programs, where there is only periodic attendance, must be constantly on the alert to be sure that new information is offered relative to what the participant already has.

Relationship of Activity

Learning is more rapid and efficient when the participant recognizes the significance of the whole question under study. Adult learning requires that people be given ample opportunity to go through all of the stages in the problem-solving process. No one can be expected to get enthusiastic about tackling a problem unless he can see the *whole problem*. This is not a unique suggestion but, too often, it is forgotten by adult program planners. One only has to recall the first reaction of a child when asked to consider something new. "Why?" "What will happen if I do?"

Dr. Alice Schwiebert of the Ohio Farm Bureau has crisply set this area of concern in the following few sentences:

I accept only what I know.

I appreciate only what I understand.

I am concerned only when I am concerned *with*.

I am responsible only to that which I helped to create.

Conclusion

The principles discussed have been considered primarily in the context of voluntary adult programing. Considerable research has been done in this field; more is required. Emphasis has been placed on the need for continuing education in relation to citizenship and its responsibilities. Programing must meet the expressed needs of the participants. Experience has shown that there would be only a minor interest in the ideals I have suggested, a situation which may be a reflection of (a) the lack of interest in these areas created in the formal schooling, or (b) the inadequacy of program techniques

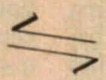
to relate the wider problems to the man-on-the-street.

Whatever the reasons in the past, future continuing educational programs will have to take account of the need for developing concern for more than a purely technical education. In a changing society, if man is to become the master and not the slave of the machine, educational programs must be designed to help him understand and accept responsibility for a part in helping to build a better and more creative society.

Continuing education, like formal education, cannot consider that it serves its purpose if it offers a conglomeration of facts that become obsolete in a few years. Continuing education to help the citizen in his relationship to his job, his community, and his fellow man must provide for the development of judgment, inference and reasoning. Dean Scharfe of U.B.C. has noted that

> What a person understands of the functional relationship between the classes of things, his understanding of the limits of such present knowledge as he has, and his insights into the need for particular kinds of additional facts, are the only truly effective understandings which lead to the successful adjustments of a situation to human needs. Fact collecting is, therefore, inadequate to the educative process.

Continuing education, at all levels, must redirect itself to help people to help themselves. It must teach by asking questions, not by giving answers. It must encourage independent thought. It must move forward, avoiding propagandist expediency, toward the fundamental objective of developing each participant toward the maximum of her potential. New organization, new finances, and continuing research will be required. Immediate steps should be taken to provide professional preparation for adult educators.



Coming!

IN

FEBRUARY 1964

Series on Mental Health and Psychiatric Nursing

plus additional material

No news releases were received this month from National Office. The "World of Nursing" section will not appear until the February issue.

SURGERY FOR OTOSCLEROSIS

G. A. FEE, M.D.

The development of technics for restoring hearing in those afflicted with otosclerotic deafness makes an interesting chapter in the story of modern surgery. A brief description of the pathology and diagnosis of otosclerosis provides a background.

PATHOLOGY

The morphology and morpho-genesis of otosclerosis has to a large extent been clarified through the work of Politzer, Siebenmann, Monasse, Mayer, Wittmark, Nager, Meyer, Weber, Guild, Griefenstein and others. It is generally agreed that otosclerosis is a primary disease of the bony labyrinthine capsule, in which circumscribed destruction of the capsule at certain typical places is followed by the formation of foci of new, at first very immature bone. It gradually becomes more mature, and sometimes reaches a higher level of maturity than the bone of the capsule itself. It may become stationary at any period of development. It may be inactive in some areas and very active in others. The number of active foci decrease with increasing age. In cases of bilateral otosclerosis, the activity in both temporal bones is generally similar. The commonest site is the area anterior to the oval window (80 to 90% of the cases). If the otosclerotic bone extends through the annular ligament into the stapedial footplate, it will produce ankylosis of the stapes, and conductive deafness. If the otosclerosis invades the cochlea, nerve deafness results. Often there is a combined type of loss. The etiology of otosclerosis, other than that there is a familial tendency, is not known at present.

Dr. Fee is on the attending staff of Toronto Western Hospital and is also associated with the University of Toronto.

CLINICAL DIAGNOSIS

Otosclerosis causes a chronic progressive deafness, usually starting in the twenties or thirties. The ear drum is normal, the patient hears better by bone conduction than air conduction, and there may or may not be a family history. It is commoner in females. It is often aggravated by pregnancy. If the bone conduction is normal, then the operation can produce almost normal hearing. If there is some loss in bone conduction, indicating some perceptive loss, the hearing will be down a corresponding amount postoperatively. It can be differentiated from chronic adhesive otitis media by the normal drum and the absence of a history of previous chronic otitis media. Serous otitis media must also be ruled out. In this condition, the drum is apt to be amber colored or opaque and the ear feels full, due to the fluid in the middle ear.

SURGICAL PROCEDURES

Three main types of operations for otosclerosis have been developed. In 1938, Lempert first described his one stage endaural fenestration. In this procedure, the mastoid cavity is exenterated, the incus and the head of the malleus are removed, and a window made in the horizontal semicircular canal. This window is then covered by a flap, created from the posterior canal skin. This produced improvement,

Reprinted from *Modern Medicine of Canada.*

but because of the loss of the ossicular chain, the hearing was still 25 to 35 decibels below normal in many cases. The disturbance of the semicircular canal produced vestibular symptoms that were often annoying. In addition, the presence of the mastoid cavity required prolonged postoperative care in some cases, sometimes with recurring infection.

In 1953, Dr. Rosen developed his technic for stapes mobilization. The ear drum was elevated posteriorly and the stapes freed by manipulation with fine picks and chisels. This procedure had the advantage of not disturbing the mastoid or the semicircular canal and the hearing level obtained was very much closer to normal than with the fenestration operation, as the ossicular chain was maintained and the immediate results were very gratifying. However, when these patients were followed over several years, about 50 per cent of the successful cases refixed, which was very frustrating, both to the patient and the surgeon, and it became evident that this procedure was not the answer.

In 1956, Dr. John Shea discovered that by completely removing the diseased stapes, closing the open oval window with a vein graft from the back of the patient's hand and replacing the stapes with a polyethylene tube, he could get close to normal hearing in a high percentage of cases. Because the diseased stapes was completely removed and replaced with an inert implant, refixation was a rare occurence. Dr. Harold Schuknecht developed a modification of this technic, using subcutaneous tissue and stainless steel suture wire with comparable results. Considerable animal experimentation was used to determine the safest technics for removing the stapes and for evaluating the best materials for the prosthesis.

Various modifications have been introduced by several otologists but the general principles are the same.

TECHNICS

After infiltrating the canal with local anesthetic, a V-shaped incision is made in the posterior canal skin. This triangle of skin is elevated; the posterior part of the drum is detached from the tympanic rim and the posterior half of the drum folded forward, exposing the posterior half of the middle ear and bringing the incus and stapes into view; this is done through as large a speculum as the ear will accommodate, using the operating microscope for good illumination and magnification (*figure 1*).

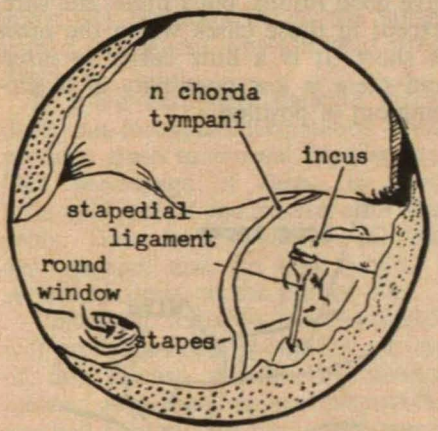


Fig. 1

The chorda-tympani nerve is either elevated out of the way or sacrificed. The stapedial tendon is cut and the head and crura of the stapes are fractured and removed, leaving the otosclerotic footplate still present in the oval window. The removal of this fixed footplate without disturbing the inner ear is the most difficult part of the procedure. The degree of difficulty varies with the type and extent of the pathology. An opening is made through the thinnest part of the footplate with a sharp needle and the rest of the footplate is removed with angulated picks. If there is no thin portion, then an opening must be made with a fine perforating burr, making a cross cut to divide the footplate into an anterior and posterior half. These halves are then loosened with fine chisels and removed with angulated picks. When the diseased footplate has been completely removed, the prosthesis is put in position. I prefer to use stainless steel suture wire, as advocated by Dr. Schuknecht — a piece of subcutaneous tissue is tied on to

one end. This seals off the open oval window; the other end is flattened into a hook and clamped onto the incus. The wire is made the exact, right size and shape by a special die (*figure 2*).

Dr. Shea's method is to seal off the open window with a vein graft and using a piece of No. 90 polyethylene tube, bevelled at one end to make the contact between the vein and incus (*figure 3*). Both of these prostheses give good results, but I prefer the wire, except in those cases where the incus is short. It is a little easier to insert and there is less possibility of it slipping out of position.

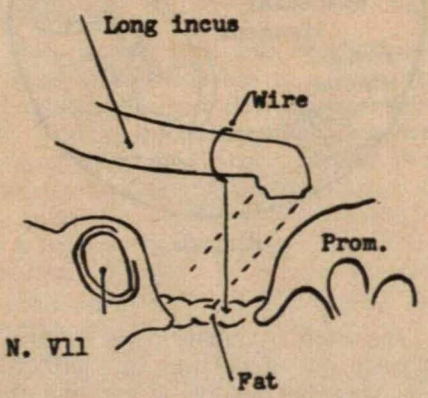
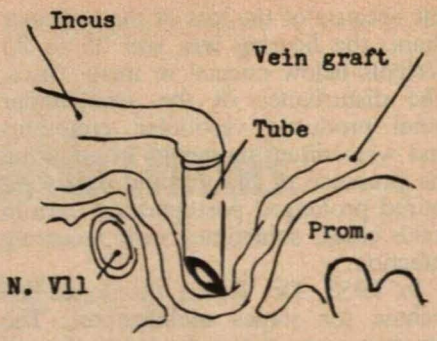


Fig. 2

RESULTS

A review of 535 stapedectomies done during the past three years at the Toronto Western Hospital is shown in the accompanying table. Some of these were done with vein graft and polyethylene tube and some with stainless steel wire and tissue graft. The results have been evaluated by averaging the hearing levels for the three speech frequencies 500, 1000 and 2000, and comparing the air conduction thresholds with the preoperative bone conduction thresholds. There was a very satisfactory improvement in 89.2%. There was a significant drop in hearing in 1.6% (see *table*). Because of this possibility of an increased loss, the operation is always done in the poorest ear.



Deep oval window recess

Fig. 3

RESULTS WITH STAPEDECTOMY

1959 - 1962

Average Duration — 1 1/2 Years

Excellent	*Satisfactory*	*Worse*
Closure of air bone gap to within 10 decibels	Closure of air bone gap to within 20 decibels	9 or 1.6%
411 or 76.7%	478 or 89.2%	

COMPLICATIONS

The morbidity is usually slight, the patients leaving the hospital the first or second postoperative day and returning to work in a week. The most serious complication is inner ear damage. Fortunately, this only occurred in 1.6% of our series, and is gradually diminishing as the factors responsible are becoming better understood.

Total stapedectomy is now recognized as the best procedure for producing consistent long-term hearing improvement. It is also the most exacting technic and carries with it some increased risk of complications.

Inner Ear Damage

Most surgeons doing this work are reporting 1 to 3% of cases with increased loss due to cochlear trauma. These can be minimized by adhering to the following principles:

Avoid stapes surgery where there is very extensive pathological change completely obliterating the oval window margin and requiring excessive drilling to remove. These cases should have a fenestration if suitable.

Avoid infection. Surgery must not be done in the presence of an upper

respiratory infection or otitis externa. Careful preparation of the ear canal and antibiotic coverage are important.

Remove otosclerotic footplate with minimum disturbance of inner ear fluid that the lesion will allow.

Control bleeding well before removing footplate.

Make certain tissue graft and prosthesis fit well.

Dizziness

This is usually not bothersome except in the occasional case where the lesion was very extensive and prolonged and instrumentation was required to remove it. Even in these cases it was not severe and seldom lasted more than a few weeks. An excessively long prosthesis may cause trouble, but this can be avoided by careful measurement of the distance between the footplate and the incus.

RECURRENCE

This has not been a problem during the four years the operation has been in use except in one type of case — those whose deafness started early in life with rapid progression. These cases tend to close over and should not have this type of surgery. In no other cases, where the stapes footplate has been completely removed, has any regression occurred.

CONCLUSION

The most effective type of surgery for otosclerotic deafness at the present time consists of: (1) complete removal of the diseased stapes; (2) closing of the oval window with a living tissue graft; (3) replacement of the stapes with a permanent well-tolerated prosthesis.

It is an extremely delicate procedure, but in experienced hands it can produce close to normal hearing in a high percentage of cases. It shows little evidence of recurrence after four years. There is a small risk of inner ear damage, and for this reason, it should be done on the poorer ear.

Continued research on otosclerosis will probably make prevention or cure of this disease possible by medical means; until this happens stapedectomy will continue to be a very worthwhile procedure.

Now Hear This

The intensity of sound (or height of the waves) is customarily expressed in decibels (db), where zero decibels is the intensity that we can barely hear. Each increase of 10 db indicates a tenfold increase of sound intensity. Thus a sound of 10 db is ten times as intense as that which is barely audible. Twenty db indicates a sound 10 times 10 or 100 times as intense, while a sound of 60 db is one million times as intense. At a distance of about 4 feet, an average whisper produces a level of 20 db and ordinary conversation about 60 db. A riveter about 35 feet away produces a sound, the intensity of which is 100 db, or 10 billion times the intensity that is barely audible. Such is the tremendous range of intensity that we are able to hear.

— CIBA *Clinical Symposium*, 15:88, June-July-Aug., 1963.

Graduates Return

Thirty-five graduates of The Hospital for Sick Children School of Nursing are returning to the Hospital to assume volunteer duties in the infant wards. These graduates, all of whom are registered with the College of Nurses of Ontario, will assist in bathing, feeding, admitting and discharging patients. They will also accompany patients to various departments for special tests. The full-time nursing staff will then be free to devote more time to direct patient care.

A smart new daffodil-yellow uniform has been designed for the volunteers. They will wear the cap and pin of The Hospital for Sick Children School of Nursing.

* * *

The number of those who undergo the fatigue of judging for themselves is very small indeed.

— PHILIP FRENEAU

IN A CAPSULE

A GOOD QUESTION !

In a recent issue of *The American Journal of Nursing*, the editors reported that a friend had brought to light an urgent problem that required immediate committee consideration: "We're just going to have to take a serious look at this 'lamp carrying' which is so closely associated with nursing's pioneer," she said. "After all, that just is not a *nursing function*."

This comment brought the following response from England:

> Obviously the States are having the same debates — as we are — on the functions of the Nurse. From my committee of ONE, I would like to report my findings.
>
> Miss Nightingale was essentially carrying out a Nurse's function in carrying a lamp, because: 1. She brought light into a ward of darkness, thus she would be seen and by her womanly presence bring comfort; 2. She was able, with a light, to carry out an essential nursing function — OBSERVATION.
>
> What my committee would like to know is: why was it always dark when Florence was on duty? — *A. J. N.*, 63:36, Sept., 1963.

CONTINUITY OF CARE

Not all hospitals avail themselves of community nursing services for their patients. Real continuity of care evolves from two key concepts — visibility and mutual interaction.

Visibility means that wherever we stand in the continuum of services, our particular service must be fully visible to everyone else in the continuum; theirs, in turn, must be equally visible to us. We must know what services are offered and be aware of the ideas, attitudes, and ideals that prevail at other levels of service. We must be able to project the patient's needs to the future when he passes beyond our immediate range of service. Visibility can be enhanced by inviting the public health nurse to the hospital to share in inservice education or patient care conferences; by emphasizing continuity of patient care in basic nursing education programs; by interpreting community nursing services to the public.

Mutual interaction implies bringing hospital and community people together in the planning, administration, and evaluation of referral systems. One way of stimulating interaction is to introduce a liaison nurse into the hospital. In one situation where a liaison nurse was assigned to a hospital, the over-all referrals increased three-fold — Lindenberg, R. *Nursing Outlook*, 11:598, Aug. 1963.

SMOKING DETERRENT STUDY

Large doses of lobeline cause bradycardia, hypotension and broncho-constriction due to central vagal stimulation; respiration is increased in rate and depth reflexly as a result of stimulation of the carotid-body chemoreceptors. These pharmacological actions are similar to those of nicotine, and for this reason lobeline preparations have been recommended as an aid to giving up smoking.

A trial was conducted in England to assess the value of a preparation of lobeline as a deterrent of smoking. This preparation (Lobidan) contains lobeline sulfate 2 mg. in each tablet. The smoking deterrent effect of this tablet was compared with that of an inert tablet in a controlled trial.

The subjects were instructed to take one tablet q.4h. for 6 weeks. Results were available for analysis on 43 subjects taking Lobidan and 38 taking the inert tablets. Results were assessed after the tablets had been taken for two weeks and six weeks, and again at six weeks after stopping the tablets.

It was concluded that the Lobidan tablets were no more effective as a smoking deterrent than the inert tablets and that a return to former smoking habits was just as likely on Lobidan tablets as if the reduction had been achieved on the inert tablets. — *C. M. A. J.*, 89:30, Sept. 28, 1963.

LEGG-PERTHES' DISEASE

A. LYNN STORIE

An account of Henri and his adjustment to a cumbersome brace.

In a small town in New Brunswick, in 1954, Mr. and Mrs. Jacques Lecours had their first child, a beautiful eight-pound boy. He was christened Henri, after Jacques' father.

The young couple were good parents. As a baby, Henri received plenty of love, care, and medical attention. He developed into a healthy, happy child who gravely accepted the responsibility of big brother to the sister and brother who appeared in the next two years.

At this time, Jacques moved his family to a town in Northern Ontario. Henri had an outgoing personality and soon made friends with the neighborhood children. He was a very handsome lad with deep blue eyes, curly black hair, and a clear, olive complexion. His body was strong, sturdy and active. He engaged in all forms of play with exceptional vigor and energy, made friends easily and yet never turned down the opportunity for a good fight.

When he was six years old, he was enrolled in the grade one class. With his usual eagerness he tackled the three "R's," and learned to speak English — even though French was spoken in his home. Around this time, Mrs. Lecours noticed a personality change in her son. His sunny disposition was now peppered with irritability. She also became aware of a change in his walk. He swung one hip slightly with each step, giving a carefree but stomping appearance to his usual swagger. One morning he complained of severe pain in his right hip and knee when he bent down to tie up his shoelace. His parents decided that a doctor's examination was in order.

The family physician found moderate limitation of both internal and external rotation of Henri's right hip with pain on internal rotation. He stated that these symptoms suggested either tuberculosis of the hip or Legg-Perthes' disease. He recommended that Henri be sent to a hospital that specialized in diseases of children.

Hospitalization

Henri was examined in the admitting department of the city hospital. When the doctor attempted to rotate the child's right hip he found limited movement in abduction and lateral rotation. Henri squealed with pain when his right leg was pushed toward his left leg.

Legg-Perthes' disease was described to Mr. Lecours. Due to a disturbance of the blood supply to the head of the femur, it undergoes a temporary softening. If weight-bearing is allowed to continue while the bone is soft, the head becomes flattened and deformed. After approximately two years the bone hardens again. The prognosis is related entirely to the final condition of the femoral head. If it remains spherical there is little danger of any residual disability; if deformity has been allowed to occur, it will not resume its normal shape and there will be a tendency toward development of osteoarthritis in later life. If weight-bearing is avoided during the stage of softening, the normal shape of the femoral head is preserved.

Mr. Lecours asked if Henri could

Miss Storie was a student at the Hospital for Sick Children, Toronto, Ontario, when she prepared this study.

possibly be suffering from tuberculosis of the hip. The doctor assured him that although the symptoms were somewhat similar, in tuberculosis of the hip *all* leg motions would be restricted. The possibility of tuberculosis was unlikely, but blood tests and x-rays would be taken to confirm the diagnosis. He also explained that Legg-Perthes' disease is more likely to occur in boys than in girls — particularly between five and ten years of age.

Henri was brought to the ward after lunch and was put in a room with five other boys of the same age. His father stayed with him for an hour to help get him settled. He promised to write to him and to take him home in a few weeks.

When I first met Henri he was gaily chattering to his new roommates and moulding a bear out of plasticine. His friendliness and creativeness were signs of normal development. He explained in great detail that his bear could be recognized by its short nose — but if it had a long nose it would be an elephant! His imagination was vivid, but his attention span was short. He soon tired of moulding and began coloring in another boy's coloring book. By the end of the day he seemed completely at home in his new surroundings.

On the second day of his hospitalization, the diagnosis of Legg-Perthes' disease was confirmed.

Treatment

This consists of complete rest of the hip joint. Formerly, it was achieved by keeping the child in bed for the two-year period that it takes the bone to harden. Modern methods of treatment are geared to meet the emotional needs of the child. A child in the age range of five to ten years would find it difficult to remain in bed for this length of time; his hip might heal more quickly, but his outlook on life could be severely damaged. Doctors have developed a method of resting only the affected joint and allowing the child to enjoy normal activities with certain limitations.

Traction: Henri's right leg was measured for a brace. It was painted with tincture of benzoin to protect the skin and make it stickier for the adhesive, and then put in skin traction. Traction is produced by weights pulling on one end of the leg with counter traction created by the weight of the body. The weights are on the end of a rope that is attached to long strips of wide adhesive stretching longitudinally from the middle of the thigh to the foot (Buck's extension).

The aim of traction was to reduce the pain of Henri's hip by immobilization. When this was explained to him, he accepted it remarkably well. He pretended that the bed cradle was the dashboard of a space ship ready to zoom into orbit. From my first meeting with this child I could see evidence of his optimistic outlook. He found amusement in all situations. He never complained about having to remain in bed for the ten days he was in traction.

While on complete bed rest, Henri required special nursing care. His back and buttocks were washed frequently and dried well. He thoroughly enjoyed a back rub with talcum powder — in fact he insisted on it. He had fun working at his prescribed exercises. He pretended his leg, in traction, was a caterpillar and moved it in this manner. There was no problem in exercising his unaffected leg since he rolled from his back to his stomach almost constantly. His abdominal muscles received adequate exercise by deep breathing and rolling his tummy "like a bowl full of jelly." He did not receive a special diet, but was given extra fluids to prevent urinary complications that could occur due to his inactivity.

It was a challenge to keep Henri occupied. He would be nicely settled coloring and then would decide to read a comic book. Since he could not really read, one comic did not last long. He turned each page and scanned each picture in a minute or two, mimicking the other boys who could read. The occupational therapy department helped to provide materials for him to color and paint as well as to weave.

At this stage Henri was a model patient. He was happy and appreciative of any extra attention, and, consequently he received a lot of it. His imaginative, dramatic play, wriggling, group play and reading are all typical of six or seven-year olds.

The Taylor Brace: Traction days

were soon over and Henri was ready for the next form of treatment. A brace was designed to keep all weight off the affected hip yet allow him to walk. This apparatus consisted of heavy thoracic straps that encircled the child at the nipple line and waist. A long metal shaft stretched from the nipple line to below the foot on the affected side. There were two wide straps holding the shaft to the leg, one above the knee and one below. Two strong bands of leather reaching from the waistband at the back, between his legs were fastened at the front and pulled tight so that he sat on them. His affected leg was kept straight by the metal shaft. His right foot was fitted for a boot that was kept three inches from the floor by the brace. On the other foot he wore a shoe with a thick cork sole to balance the added height.

The day the physiotherapist brought Henri his brace, his eyes shone with delight. When he realized he would soon be walking he was radiant. After his final walking lesson by the physiotherapist, he returned to the ward boasting of his skill and exclaiming how nice it was to be rid of the traction.

A personality change took place in Henri. After breakfast he cried and whined if he could not have his brace on immediately; once in his brace he disappeared until lunch time. He shunned any aid in walking, and no longer wanted any extra attention. He stood for lunch so he would not have to remove the brace. He took great pride in keeping it in the big white bag that was attached to the head of his bed while he was sleeping.

During this stage of his illness, I observed the skin areas where the straps rubbed. Since a reddened area was evident at the left groin, the physiotherapist loosened that strap one notch.

Conclusion

Two weeks after he had been admitted, Henri was ready for discharge. His parents were notified and soon arrived to take him home. They had been advised what to expect, but were rather alarmed by the sight of the large brace. Henri proudly demonstrated his walking skill to his father. Mr. Lecours agreed that if Henri was happy with his brace, he certainly would be too.

The care of the brace was outlined to Henri and his family. It had to be kept clean and oiled in order to function; the left shoe had to be kept in good repair since a worn-down heel would change the weight-bearing line in knee and hip; leather parts had to be cleaned with saddle soap to prevent damage from perspiration and then treated with a special leather conditioner. The brace had to be protected from dust and falls while not being worn.

Mr. Lecours had already been advised to purchase a three-legged stool for Henri so that he could rest the left side of his body while the right side was kept straight in the metal shaft. The father realized the importance of keeping Henri off his affected leg.

In about two years, Henri will be able to discard his brace. He will then be able to work and play like any other boy his age.

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No Complaints?
Then Watch Out!

Psychologic factors may play a role in rheumatoid arthritis. When asked what they would like to change in themselves and in their lives, patients with rheumatoid arthritis wanted fewer changes than either non-hospitalized or hospitalized males with duodenal ulcers. They were also less likely to remember having been angry within the past year or to remember when last they had been angry. — *Patterns of Disease.*

The Psychoses of Childhood

LISETTE PERRON

As little is known of the origin of the psychoses of childhood, this article is an attempt to define some of them and to point out the principal signs and characteristics in such a way as to show the mode of treatment which suits each psychosis.

Types

1 *Spitz "Hospitalitis"*

Definition: Physical deterioration following prolonged hospitalization. This is seen during the first year of life.

Signs: The IQ falls to about half the expected value for one-year-olds and declines further in the second year;

the infant is highly susceptible to sickness;

the mortality rate is very high.

Mental deterioration and poor physical development are essentially due to the lack of affection usually found in the mother-child relationship.

2. *Anaclitic Depression*

Definition: All babies who are just about to establish a satisfactory relationship with their mother and lose the mother-object react with extreme depression capable of leading to general debility and even death.

Signs: The infant possesses a sad countenance and a tendency to cling to whoever comes to him despite the fact that this person is not the infant's mother. He is characteristically timid and cries readily;

depression persists even if the child accepts the substitute;

if this continues, the child looks tense and is withdrawn in manner.

If the natural mother-child relationship is restored, the child becomes cheerful and friendly; otherwise, the process continues and eventually he appears to be dazed.

Miss Perron, a student at St. Justine's Hospital, Montreal, was studying at St. Jean-de-Dieu Hospital, Montreal, when she wrote this article.

3. *Kanner's Infantile Autism*

Characteristics: Profound withdrawal; lack of association from infancy;

a "sameness" obsession in which the child wants his toys always to be kept in the same place or he makes a scene and cries;

lack of ability to communicate;

preference for relationships with inanimate objects.

This phenomenon occurs in the first year of life.

4. *Makler's Symbiotic Psychosis*

Normally a phenomenon exists called separation-individualism.

In the psychotic condition the child is not able to distinguish what comforts him from without from what troubles him within.

5. *Infantile Schizophrenia*

Definition: This is a clinical entity which occurs in childhood before the age of eleven years. It is characterized by pathological behavior at all levels and at all areas of integration of the nervous system's functions: vegatative, motor, sensory, intellectual, emotional, and social. There is a lack of development of the biological processes. Furthermore, there is abnormal concern on the part of the child over bodily development and his relationship to objects around him; severe difficulties in orientation and also in the meaning of language.

The aim of the treatment is: To increase the integrity of his impression of the body; to develop means of communicating; and to restore the "id" functions.

Psychotherapy

1. *Supportive:* The object is: To

reinforce the defense mechanisms which already exist;

to develop new and better defense mechanisms in order to maintain control;

to restore emotional equilibrium.

Techniques of Approach:

Orientation;
diversion of interests;
confidence;
pressure;
persuasion;
easing the emotions with desensitizing, muscular relaxation, hypnotism, hydrotherapy, pharmacotherapy, convulsive shock treatment;
group therapy.

2. *Insight* — rehabilitative: Development of insight into conflicts or problems with a determined effort for adjustment, modification of objectives, and the development of creative potential.

Techniques of Approach

Attitude and relation therapy;
psychotherapeutic interviews;
analysis and synthesis;
psychobiological therapy;
case history;
speech therapy.

3. *Insight* — reconstructive: Insight into the unconscious conflicts with an effort to bring about important changes in character structure, to develop the personality, and to develop new methods of adjustment.

Techniques of Approach:

Freudian psychoanalysis;
non-Freudian psychoanalysis;
psychoanalytic therapy.

Summary

The importance to a child of a healthy upbringing in a stable, pleasant environment offering good relationships can be deduced from the foregoing.

The child needs abundant affection. From birth he needs the relationship with one person, his mother, and in one place, his home. This is why he should not live in a public nursery where babies suffer from the lack of maternal love; later they may become juvenile delinquents. This is also a period during which the child needs repeated gratification of his physiological needs, which contribute to the first human relationship and to a feeling of confidence and security.

Later, the child explores the world around him, differentiates himself from others, and gets into everything. If his endeavors are forbidden he will not enjoy his exploring; this inhibits his sense of adventure and he will not be resourceful. Firmness plus sensibly limited freedom will allow him to develop spontaneity and to accept reasonable measures of control.

Later, the child learns to recognize the family. Good feeling must exist in parent-parent and parent-child relationships. Questions concerning sex should be answered clearly and without embarrassment. In fact, the child should be encouraged to query such matters while at the same time he must not be given information for which he is not yet mentally prepared.

The child needs a family atmosphere of respect, integrity and love. Furthermore, he needs the opportunity to identify himself with the parent of the same sex, for this allows him to evaluate and to search into the family relationship and to secure sexual identity.

From six to thirteen years, the child must be successful at his own level and must receive encouragement without consideration of his scholastic rank. He acquires status as an individual within the family. The fulfillment of these emotional requirements allows him to form a sense of ability, of competence and even of superiority.

Sin has many tools, but a lie is the handle which fits them all.

—Oliver Wendell Holmes

No woman should ever be quite accurate about her age. It looks so calculating.

— Oscar Wilde

Nursing Profiles

WINNIFRED M. JAMES has been appointed regional director with the Victorian Order of Nurses for the western provinces. A graduate of Victoria Hospital, London, Ont., she did postgraduate study in public health at the University of Western Ontario and in administration and supervision at the University of Toronto. Miss James joined the VON in 1949 and has held various staff and nurse-in-charge positions in Ontario and Nova Scotia. She is a former regional director for the southwestern Ontario area.

WINNIFRED JAMES

ROSELLA CUNNINGHAM, a graduate of the University of Toronto School of Nursing, has been appointed regional supervisor, public health nursing branch, Ontario Department of Health. She obtained her B.Sc. N. from U. of T. in 1950.

Miss Cunningham joined the Victorian Order of Nurses shortly after graduation and held staff or charge nurse positions in Windsor, Carleton Place and Woodstock, Ontario. This was followed by two years of service with the Ottawa Board of Education. In 1946 she joined the Northumberland-Durham Health Unit as senior nurse and remained until 1960 when she was appointed director of public Health nursing with the Metropolitan Windsor Health Unit.

ROSELLA CUNNINGHAM

The School of Nursing, Dalhousie University has annouced the appointment of ELIZABETH R. SUMMERS, former director of

ELIZABETH SUMMERS

nurses of St. John's General Hospital, Newfoundland, as a lecturer. A graduate of Halifax Infirmary, she received her Bachelor of Nursing from McGill University, specializing in public health nursing.

A nursing sister with the Royal Canadian Navy during World War II, Miss Summers joined the Department of Health, Newfoundland in 1946 as a staff nurse. In 1955, she was appointed associate director of the provincial health services and in 1956 went to St. John's General Hospital. Active in the work of her professional association, she was successively secretary, then president of the Newfoundland Graduate Nurses' Association and in 1954 became the first president of the ARNN as Newfoundland became the 10th of the Canadian provinces. Those attending the Banff convention in that year will undoubtedly recall the ceremony in which Miss Summers participated as this newest member of the provincial associations was welcomed into the membership of the CNA.

The new director of nurses of St. John's General Hospital, Newfoundland is JANET STEER STORY, a graduate of the hospital's school of nursing and a staff member for several years.

Miss Story is a Newfoundlander by birth, and was educated in that province. She did postgraduate study in clinical supervision at the University of Toronto and recently obtained her Bachelor of Nursing degree from McGill University. She has already served her hospital as a supervisor and clinical instructor.

She is the immediate past president of the Association of Registered Nurses of Newfoundland. You will be seeing her at the 1964 Convention.

Names in the News

The International Council of Nurses has announced the appointment of an assistant director to the Social and Economic Welfare Division. She is **Mary Patten** of Australia who assisted with arrangements for the ICN Congress in Melbourne . . . **Dr. Rae Chittick**, former director of the School for Graduate Nurses, McGill University and presently, by appointment of WHO, director of the postbasic program for nurses at the University of Accra, Ghana, is busy with arrangements for establishment of the new program. Assisting her is **Mary Heron**, Montreal General Hospital graduate and of Mc Gill University where she secured her Bachelor of Nursing degree in hospital administration . . . **Sarah Wallace**, industrial nursing consultant for Ontario, was one of three nurses elected to the Permanent International Commission on Industrial Medecine. Inclusion of nurse members on the Commission is considered recognition of the part taken by the profession in the practice of occupational health . . . **Myrtle Pierce**, Toronto General Hospital graduate, was awarded honorary life membership in the Saskatchewan branch of the Canadian Public Health Association after 34 years of public health service with that province's Department of Public Health . . . Recent additions to the staff of the School of Nursing, University of Toronto include:

(Campbell & Chipman, Winnipeg)

MAY WATANABE

Willa J. Routledge, presently on leave of absence from WHO; **Phyllis E. Jones**, formerly with the Toronto branch of VON; **Hazel K. Wilson**, graduate of Ottawa Civic Hospital and until recently a regional supervisor in public health nursing with the Ontario Department of Health and **May Watanabe**, graduate of McMaster University

School of Nursing and for the past year predoctoral associate, School of Nursing, University of Washington . . . **Dorothy Joan Eagle** has been appointed lecturer in nursing at her Alma Mater, the School of Nursing, McMaster University. She recently completed the requirements for her Master of Nursing from University of Washington, Seattle. Miss Eagle was formerly with the VON, holding senior positions in Barrie, Ont. and Montreal.

JOAN EAGLE

Almost all absurdity of conduct arises from the imitation of those whom we cannot resemble. — SAMUEL JOHNSON

* * *

People who want to live in the past are victims of infantile regression. History is to *build on*, not to *dwell in*. — MARCUS LONG

MEET THE AARN EXECUTIVE

Front row: Left to right, Sister Xavarius, Rep. the Nursing Sisterhood, Miss J. Lewis, Pres., Dr. Chittick, guest, Miss P. Laracy, Exec.-Sec., Sister M. St. Clare, 3rd Vice-Pres. Back row: Left to right, Major M. Lydall, Councillor, (Miss E. Summers), Mrs. M. Abbott, Rep. St. John's Chapter (Capt. Dockeray)*, Mrs. J. Shave, Nominating Committee, Capt. E. Hill, 2nd Vice-Pres., Mrs. M. Marsh, Nominating Committee, Mrs. V. Ruelokke, Councillor.*

* *Miss Summers and Capt. Dockeray have accepted other appointments, and are no longer on the ARNN executive.*

In Memoriam

Dorothy Margaret Jack (Vancouver General Hospital '20) died in Vancouver on October 6, 1963. Miss Jack was a former supervisor of Red Cross Outpost hospitals in British Columbia.

* * *

Sarah Louise (Hislop) Kelly (Brantford General Hospital, Ont. '29) died during 1963.

* * *

The death of the following graduates of Vancouver General Hospital is recorded with regret: **Frederica Wilhelmina Evans** '20; **Margaret Bessie (Moffatt) King** '33; **Frances Joyce (Humpage) Lesley** '49; **Dorothy Bertha (Pickering) Siveny** '23 and **Margaret Betty Marilyn (Mjos) Whitfield** '56.

* * *

Patricia E. (Lillemo) Kohlert (St. Paul's Hospital, Saskatoon '63) died as the result of a traffic accident on October 23, 1963. She was engaged in postgraduate study at the University of Saskatchewan School of Nursing at the time of her death.

* * *

Anna V. (McPhee) McDiarmid (Orillia General Hospital, Ont., '12) died in the General Hospital, Almonte, Ont. in June, 1963 after a short illness. She was one of the earliest graduates of her school of nursing.

* * *

Desneiges Pilot (Ste Justine's Hospital, Montreal '35) died as the result of an accident in August 1963.

* * *

Lucie (Baron) Renaud (Ste Justine's Hospital, Montreal '15) died recently. During World War I she served overseas with No. 4 Canadian Army Medical Corps. Upon her return to Canada Mrs. Renaud resumed professional practice and was on the staff of Ste Justine's Hospital 1941-57.

* * *

Doreen Margaret (Lightfoot) Roblin (St. Paul's Hospital, Vancouver '56) died in Vancouver on July 24, 1963.

* * *

The alumnae association of the Royal Alexandra Hospital, Edmonton pays tribute to the memory of **Elizabeth Gordon (Fraser) Nelles** '26 who was charge nurse of the Women's Medical Pavilion, Baker Memorial Sanatorium, Edmonton for many years, and **Margery (Dunstan) Postoluk** '34, a school nurse on the staff of the Edmonton City Health Department.

* * *

Constance Iona (Matthew) Salmon (St. Joseph's Hospital, Chatham, Ont. '28) died recently in Chatham.

* * *

Edna L. Shannon (Buffalo General Hospital, N.Y. '19) died during July 1963 in Vancouver, B.C. following a long illness. For many years she was head nurse on the private ward, Regina General Hospital.

* * *

Mona K. L. Sharpe (Women's College Hospital, Toronto '38) died in Florida earlier this year.

* * *

Sister M. Petronilla (St. Joseph's Hospital, London, Ont. '17) died early this year in London.

* * *

Sister Marie Jeanne Louise (Solange Lévesque, Hôtel-Dieu Hospital, Quebec City '59) died as the result of an accident in August 1963.

* * *

Sister St. Paul (Berthe Bouchard, Hotel Dieu Hospital, Chicoutimi, '47) died this fall in a car accident.

* * *

Charlotte Elizabeth (Globe) Smith (Hamilton General Hospital, Ont. '60) died recently in Burlington, Ont.

* * *

Muriel E. Toland (Kingston General Hospital, Ont. '26) died late last year. She had engaged in private nursing.

* * *

Elizabeth Wilson (Edinburgh Royal Infirmary, Scotland '19) died as the result of a car accident in Vancouver on September 8, 1963. Miss Wilson came to Montreal shortly after her graduation from the Royal Infirmary. During World War II she joined the hospital surgical division of Cornell University, New York. In 1957 she retired and moved to Vancouver to be with her sister, Grace M. Fairley.

Renal Calculi with Nephrectomy

MARIE GERMIN

A student discusses the care of a patient who required kidney surgery.

Mr. Van Horne came to the hospital emergency department at 3:00 a.m. complaining of severe pain in the left loin. A quarter of a grain of morphine was administered subcutaneously, and an intravenous pyelogram was performed at once. The results of the X-ray showed clacifications overlying the renal pelvis of the left kidney.

The pain had subsided by the time the patient was admitted to the ward. Later that day, a cystoscopic examination was carried out followed by left ureteral catheterization. During this procedure a small calculus was removed. Radiopaque dye was then injected up the ureteral catheter and X-rays were taken to outline the area. The diagnosis of calculi in the left renal pelvis was confirmed.

During the day, solid foods were withheld though clear fluids were encouraged. The patient was given Demerol 100 mg. as a preoperative sedative hal an hour before the cystoscope was introduced under a local anesthetic. He withstood the procedures well since explanation beforehand had prepared him for them. Following his return to the ward, Mr. Van Horne was offered fluids hourly for a four-hour period. His urine was observed for hematuria. When he complained of a burning sensation in the bladder, he was given a mild analgesic.

A nephrolithotomy was the surgery planned. When the kidney was exposed, a small yellowish tumor was found. This appeared to be a hypernephroma — a tumor derived from the cortical tissue of the suprarenal gland. It was decided that a left nephrectomy was necesary. During the operative procedure, 1,000 cc. of blood was given to compensate for blood loss. The kidney specimen was sent to the pathology department and the report returned indicated the presence of calculi and an adenomatous tumor. This growth is benign, but it can be a precursor to renal carcinoma.

Postoperative Care

Mr. Van Horne was returned to the ward from the recovery room when he was fully conscious. Because of the site of the incision, it was painful for him to breathe deeply. Analgesics were administered every four hours for the first two days so that deep breathing and coughing exercises could be carried out hourly. The use of this medication also made it easier for him to turn from side to side. On the second postoperative day, he sat on the edge of the bed; on the third day, he was able to walk about the room for a few minutes.

Abdominal distention is frequently a cause of discomfort following kidney surgery. Mr. Van Horne complained of nausea and abdominal pain even though food and fluids had been restricted for the first twenty-four hours postoperatively. Relief was obtained after a rectal tube was inserted. Five days after surgery, he was given a mild laxative that had the desired effect.

Sips of warm fluids were allowed on the second postoperative day. By the third day he was able to tolerate a soft diet. Intake and output were accurately recorded.

Further Care

The patient became quite upset when the physician told him that his kidney had been removed because of a tumor. He was assured that it was benign, but seemed to feel that he was not being told the truth. He spoke of a man of his acquaintance who had had an oper-

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Miss Germin was a student at Misericordia Hospital School of Nursing, Edmonton, Alta., when she prepared this study.

ation, had been told that "all was well," and had died a few months later of cancer. Eventually Mr. Van Horne became convinced that his prognosis was good, and that his physician was telling him the truth.

He asked many questions concerning his illness and recovery: How would urine, previously excreted by the left kidney, now be removed? What would happen if a tumor should develop on the remaining kidney? Should he drink less fluid so as not to overtax this kidney? Would early ambulation cause the incision to "break open"? Explanation and reassurance from the physician and nurses seemed to answer his questions satisfactorily.

Before his discharge, twelve days after the surgery, Mr. Van Horne was given instructions regarding his convalescence at home: He was reminded to continue to force fluids to equal three quarts daily; to avoid upper respiratory and any other infections; to decrease the calcium intake in his diet; to report to his physician for checkups if he contracted any infection.

Osteogenic Carcinoma

MARGUERITE MCLEOD

A teen-ager's reaction to radical surgery

June 6.

Dear Diary:

Let me introduce myself. My name is Judith Sutton. I am 18 years old and have just finished writing my Grade 12 final exams. (They weren't too hard). Now I'm in hospital having tests for a lump on my left shin bone. It seems rather silly to me. Granted, it's not very glamorous looking, but I don't know why they're making such a fuss about it. Mother made me go to the doctor because I tire easily and have had pains in my leg that waken me at night. She noticed that I limped when tired. I am active in sports and I guess maybe I bumped it. I can't remember. As for being tired, everyone gets that way during the last two months of school with exams and graduation. But I guess you know how mothers are!

I just came into the hospital last night. First thing this morning (before breakfast, even) two girls came to take some blood from my arm for tests. They called themselves "lab. technicians." After breakfast, a girl came in with a wheelchair and took me to a department where I had X-rays of my chest and legs. Later on Dr. North came in. He said that they plan to take me to the operating room tomorrow morning and remove a small part of the lump to do tests on it. I think the whole thing is silly. Making such a fuss over a little lump!

A demain,

Judy

June 7.

Dear Diary:

I sure am tired tonight. The nurse woke me at six this morning to have my bath. She put a babushka on my head, a name tag on my gown, and then gave me a needle. After that I don't remember much. I do remember riding on a stretcher and seeing Dr. North. Some one put another needle in my arm and the next thing I remember they were putting me back in my own bed. I've got a small bandage over the lump. It bothers me some, but not too much.

Daddy came up to see me tonight. He

Miss McLeod was a nursing student at the Saskatoon City Hospital School of Nursing, Sask., when she wrote this article.

didn't look very happy but said he had had a hard day at the office. (He's the manager). Mom couldn't come because she had a headache.

Now we've got company in the room. Daddy brought me a TV set. I'm too tired to watch tonight though.

Until tomorrow,

Judy

June 8.

Dear Diary:

This is the blackest day of my life. Dr. North came in this morning looking as if he had lost his last friend. He sat down on my bed and said:

"Judy, I have some grave news for you. The tests have revealed that the lump on your leg is of a serious nature. We are quite sure that we have found it before it has had a chance to spread to other parts of your body. I talked to your parents yesterday so they are aware of this and of the implications. If we allow this lump to remain, it can endanger your life. What I am going to tell you now will no doubt be hard for you to accept. But you are eighteen and a mature young lady and I am confident you can handle the situation. If you go on as you are I'm afraid your days will be numbered to a year or eighteen months. If you allow us to operate, we will have to remove your leg above the knee, but we are quite sure your life will be spared. Your mother and father have left the decision up to you. Whatever you decide will be acceptable to them. I realize this is a hard thing for you to decide, but I feel confident your decision will be the right one."

That wasn't all, Diary. He talked to me for about an hour, but I can't remember the rest. I cried and cried. He gave me a needle and I slept for a while. When I woke up Mom and Dad were here. It was a funny visit. After about an hour (it seemed like three hours), Pastor James knocked at the door. Mom leaned down to kiss me as she left, and said "Be brave dear, we'll be praying." Pastor James and I talked of many things. The short while I spent with him seemed to make me feel more peaceful. It is a great comfort to know that if I place my trust in God, He will show me the way. He won't care if my leg is whole or a stump; He only cares about my soul. And I owe it to mom and dad to be brave and fight this battle of mine. They didn't love and care for me for 18 years to have me give up at the first sign of trouble.

Here's the nurse with something to make me sleep so . . .

Good night, Diary.

Judy

June 9.

Dear Diary:

This morning, Dr. North told me that the operation should be done as soon as possible so the lump won't have a chance to spread. I asked him if it was cancer. He hesitated a minute and said, "Yes I'm afraid it is. This type mainly occurs in boys from 10-18 years old. But of course there are always exceptions to the rule. Your X-rays lead us to believe that it hasn't spread. But the sooner we operate, the better your chances will be."

I was really shocked. I thought only old people had cancer. But I told him that I figured he knew best and whenever he wanted to operate was fine with me. He said he would try to book the operating room for tomorrow. That jolted me too, but I guess the sooner it's over the better. It would be worse if I had to sit and think about it for a week or so. In the afternoon, the lab. technicians came to get some more blood from me to match with blood for a transfusion — in case I need one. A little later, the nurse scrubbed my leg with a white, watery soap. Boy, is it sticky! After that, the physiotherapist came to teach me exercises. I have to take deep breaths so I won't get congestion in my lungs. While I'm still in bed I must do push-ups to strengthen my arms because I'll be walking on crutches when I first get up. She says it won't be too hard to strengthen me since I'm in good physical shape from "track and field." Thank goodness for that. There are a lot of "do's" and "don'ts" with regard to the position of the stump. If I hold it a certain way too long or too often, it will more or less stiffen in that position, so I have to take care not to do that. She also mentioned something called "phantom pain." It is a feeling, after an amputation, that the whole leg is still there. It can be conquered but it sure sounds eerie.

Judy

June 9.

Dear Diary:

Just a short note. I'm all ready for bed

except for a sleeping pill. I had my leg washed again and also had an enema — which I would gladly have gone without. About 8:00 p.m. the doctor who will give me my anesthetic came in. He didn't do much — just listened to my chest and asked me if I had a cough.

You know, I'm trying not to think about it, but I'm really quite scared of the whole thing. I'm trying to be brave for Mom but I sure don't relish the idea of going around for the rest of my life with only one leg. I'll be a freak! I know that's not the proper attitude, but that's how I feel deep down. Well, Diary, there's no telling when you'll hear from me next.

Au revoir,
Judy

June 14.

Hello again:

Well, it's all over now but the shouting. It's hard to say how I feel. Relieved in a way, and yet I feel a little fluttery in my stomach when I look at "it" sometimes. I know now what the physiotherapist meant by phantom pain. The other night I sat right up out of a sound sleep and I could have sworn I had two legs. It's not really a pain but a very odd feeling. I think if you thought about it long enough you could go crazy. They have a tourniquet on the end of my bed in case something happens and the stump starts to hemorrhage. It's rather a stern reminder. I have to be careful how I let the stump lie and I turn on my stomach two or three times a day to prevent contractures. (I'm learning all sorts of new words). In a few days, they'll take the stitches out and then the real work will begin. I'm not just sitting here, though. I took French in High School so I thought I'd like to study another language. Yesterday, Mom brought me books of elementary German. At least I'll feel I've accomplished something.

So long,
Judy

June 18.

Dear Diary:

I had my stitches out yesterday. The scar is dry, so I was able to go to the physio. department this afternoon. Miss Sands put an elastic bandage on my stump. It feels tight after all that loose gauze. In a few days she'll start routines to toughen the skin and exercises to strengthen the muscles that I'll use to walk with an artificial leg. From what I gather that's just about every muscle I own! I'm getting used to looking at "it" now. I guess it's like everything new — it just takes a while. Miss Sands gave me some weights to exercise my arm and good leg. I'll be an amazon before they're finished! The German studies aren't too bad but the verb conjugations — ugh!

Auf Wiedersehn,
Judy

June 30.

Dear Diary:

I'm in a bit of a rut. I do the same things every day at the same hour. I wash the stump about nine in the morning and again at nine in the evening. At 10:00 a.m. I go to physio. to have my skin tanned like a piece of leather. Miss Sands taps it with her fingers, claps it with her hands, kneads it like a loaf of bread, sands it with one of the soft hospital towels, and scrapes it with a brush. Then to top it all off, she rubs salt on it. By this time it feels like an open wound. All this is to toughen it so that I can wear an artificial leg without getting sores. I wear an elastic bandage to mould the stump to a cone shape. (I need two or three more hands to put it on). If I'm lucky it looks good by about the third try. I have to do all this myself so that I can do it when I get home. I walked with the stump on a table the other day to try and adjust it to carrying weight. It nearly killed me. It *really* hurt! Miss Sands says there's a nerve too close to the skin — so now I'm having ultra-sound treatments. The machine they use sends out high frequency sound waves and these take away painful sensations. It's getting better bit by bit. Dr. North has been telling me all along that I must do things for myself and live my own life. At first the nurses babied me, along with everyone else. But they soon stopped. My main problem now is Mom and Dad. They'd feed me if I'd let them. I guess I liked it at first but it rather annoys me now. By the way, I'm also up walking on crutches. I was as wobbly as a newborn colt at first, but I can really zip along now. I'm trying to think of what I can do for a career. Dr. North doesn't think I'd be able to nurse as I'd have to be on my feet too much. I have a notion to go to college and take a liberal arts course to begin with, then maybe go on to something else.

Cheerio. Judy

July 15.

Dear Diary:

This is my red letter day. I'm home. From now on I go to physio. once a day as an out-patient. Isn't that wonderful? I'm so excited I can hardly sit. In a week I go to the limb-makers to be measured for an artificial leg. (The correct term is "prosthesis"). Dr. North says he's proud of the quick recovery I've made. Boy, if it was any slower I don't know what I'd do. A nurse from the Red Cross came to talk to Mom, Dad and me yesterday about the various kinds of legs. They have a type that lace on like a corset but I don't think I want that. Daddy was interested in a new model that has the stump fitting into a suction socket. It has a piston at the knee and one at the ankle. When you set your heel down, the toes find the level of the ground themselves without moving your weight over the foot. The part I like best is that it's made out of the soft plastic that dolls are made from, and they look and feel more like skin than any other model. But they cost $600! Daddy says he figures it's worth the money though since I'll have to walk on it the rest of my life. It may sound silly but I'm getting excited about my new leg. Once I have two feet I'll be able to walk like anyone else. I'll dance, play golf, swim, and drive a car (as long as it has automatic transmission). There'll be no stopping me. The nurse says I'd be smarter to have the leg made for a low heel. The higher heels are an awful temptation though. I suppose people will stare at an artificial leg as much as they do at only one leg. I'm sort of used to that now so it won't make that much difference. I'll still have to use my crutches for a while after I get my leg. Then I'll graduate to two canes, then to one cane and then to none. I will be able to start college this fall. If I work hard I'm sure I'll manage.

Well, Diary, you've been a comfort to me. I could talk to you when I couldn't talk to anyone else. I'll try and keep you posted on my progress. With God's help I know everything will turn out well.

Au revoir,

Judy

In The Good Old Days

(*The Canadian Nurse* — JANUARY 1924)

There is a whisper of criticism, heard only occasionally in high places, that the product of the more scientific training is not as competent as her predecessors. We do not think that the time is ripe for a just appraisal, and, when that appraisal is made, many factors will have to be taken into consideration. It must be remembered that the young woman of to-day is vastly different from the young woman of even a decade ago. We must bear in mine that a nurse who graduates from a training school can take out of it only in proportion to what she brought into it. Character may be intensified, but not completely changed in a training school.

When our society, as a whole, is more imbued with humanitarian ideals and the desire for unselfish public service, the whisper of criticism of the modern nurse will no doubt disappear. In the meantime, in the interests of humanity, the scientific training, which teaches a nurse how to observe, what to observe, and how to express accurately her observations, must be continued and improved. The pessimistic critics of modern nursing education would almost have us believe that a dull or passive mentality, combined with obedience and devotion, is the ideal for a nurse. We must never forget that, in a living ideal of service, there must be an intellectual element to keep it fresh and free.

* * *

Since World War I, five universities in Canada have established a year's post-graduate course in public health nursing. These are the University of British Columbia, Western,, Toronto, McGill and Dalhousie. In addition, McGill gives a year's post graduate course for training school instructors and administrators. U. B. C. has had the vision and courage to establish a course of five years, leading up to a degree of science in nursing. The first two years are spent in the University in a combined course of Arts and Science, the next two in the training school of the Vancouver General Hospital, and the fifth year is elective in public health or administration.

Latest Food Fad May Be Dangerous

Scientific reports linking cholesterol and heart attacks have touched off a new food fad . . . But dieters who believe they can cut down their blood cholesterol without medical supervision are in for a rude awakening. It can't be done. It could even be dangerous to try.

There are several reasons why:

For one, an individual cannot know how much cholesterol his blood contains until this is determined by laboratory tests. By the same token, he cannot know whether any diet changes have raised or lowered his blood cholesterol level unless it is scientifically measured.

In the second place, a person's entire food intake must be precisely regulated to lower blood cholesterol. Willy-nilly substitution of a few food items without over-all control of the diet accomplishes little if anything in reducing cholesterol.

What is more important, the elimination of certain foods of proven nutritional value could be detrimental to health.

Success in reducing blood cholesterol by dietary regulation so far has been achieved only in strictly controlled experimental groups, and use of this method remains largely experimental.

The carefully calculated diets used in medical research to lower cholesterol actually are not yet of practical importance to the general public.

There have been few investigations on the effect of different types of fat in the normal diet over a long period of time. For this reason, it is not known what type of fat, if any, may be beneficial in preventing heart disease, nor is it known that certain fats are harmful. Moreover, it has not been determined whether a significant change in cholesterol levels can be obtained in the American population by dietary means.

While much remains to be learned about cholesterol and other aspects of nutrition, scientists do know that the American diet provides all the nutrients essential to health and that a varied diet is the best way of maintaining a high level of health. The virtual absence of dietary deficiency diseases in this country attests to this fact.

The American diet did not happen by accident. It resulted from much accumulated research and experience. Any changes in a diet of such proven worth must await much more study and experience.

It is for these reasons that neither the Food and Nutrition Board of the National Research Council nor the AMA Council on Foods and Nutrition has recognized the need for modification of dietary fat for the general public.

For good nutrition, the AMA council recommends a well-balanced diet chosen from the "basic four"* food groups. Even those on weight reduction regimens need food from all these groups.

Although some day science may come up with a diet that can prevent heart disease, such a development appears to be well in the future. It probably would take a generation to prove whether any diet can reduce deaths due to heart or blood vessel disease.

To test such a theory adequately requires a large-scale, long-term study. Since scientists do not know whether such a mass study of diet modification could be carried out, the essential first step is to find out. It has been announced that five medical centres would begin a joint effort to seek the answer. This preliminary study alone is expected to take two years.

In the meantime, advancing knowledge may reveal other factors of possibly more importance than cholesterol in heart disease. For example, the effect of various kinds and amounts of carbohydrates, such as sugars and starches, is being investigated. and there is some evidence they may be a factor in this disease process.

At the same time, researchers are seeking other ways to lower cholesterol. Some experts believe drugs will eventually prove to be the preferred method.

—News release of the American Medical Association reprinted in *Canadian Nutrition Notes.*

* The U.S. equivalent of Canada's Food Guide.

It should also be remembered that an elevated blood cholesterol level is only one of the factors implicated in heart disease. Other important factors are heredity, high blood pressure, stress, and smoking.

The anti-fat, anti-cholesterol fad is not just foolish and futile, however. It also carries some risk.

When certain food are dropped from the diet, they must be replaced by foods containing the same nutrients, or the lost nutrients must be made up with additional foods, to achieve adequate nourishment. This requires, among other things, a precise knowledge of the nutritional content of specific quantities of a whole range of food products. And this is where the danger arises. Without this knowledge, the average person is unable to replace the nutrients he loses when he decides to stop eating certain foods and thus runs the risk of shorting his body of some essential nutrients.

The current concern about diet reflects a healthy interest on the part of the public. This interest should be directed away from hopeless pursuits to a worthwhile goal that can be attained by most individuals — maintaining normal weight. Overweight plays the villain in many diseases, and overweight can be avoided by not eating more calories than the body needs.

About Books

Nursing Service Administration by Edythe Alexander, R.N., M.A., Phoebe Gordon, M.S., Deborah MacLurg Jensen, R.N., M.A., Dorothy Rapier Meeks, R.N., M.S., Cecilia M. Perrodin, R.N., M.A. and Frances Purdy, R.N., B.S., M.Litt. 270 pages. The C. V. Mosby Company, Saint Louis, Mo. 1962.

Reviewed by Isabel Hagan, Assistant Director, Nursing Service, Toronto, General Hospital, Toronto 2.

The interdependence of nursing service and nursing education is receiving much prominence today, say the authors of this publication, but the uneven progress of these two fields has resulted in misunderstandings and frictions that accompany such a cultural lag. This well-written text is intended to increase the availability of source material for those in nursing service administration, thus narrowing the gap.

An excellent bibliography indicates a solid background for the discussion of problems and challenges facing nursing service today. Principles are well stated; some sound suggestions for their application are presented. Thoughtful, helpful suggestions are available in the sections on personnel policies and practices, and the utilization of personnel.

The approach to nursing service administration is patient-centred and should be of assistance at any level of nursing administration.

The Head Nurse by Jean Barrett, R.N., M.A. 397 pages. Appleton-Century-Crofts, New York. 1962.

Reviewed by Mrs. Margaret Ross, Head Nurse, Brockville General Hospital, Brockville, Ont.

Too few books have been written on this pertinent subject. The role of the head nurse is a complex one; guidance is imperative. The author offers a wealth of material, coherently presented. Its appeal should reach not only to the head nurse but to all nurses, who should be cognizant of basic administration. It should be recommended reading for senior students.

Part I, dealing with the role of the head nurse in today's hospital, presents excellent direction in administration. Subject material is well set forth and includes the broader aspects of the subject as well as important details. Objectives are instructive and enlightening; anticipated changes in the development of nursing provide much food for thought.

Part II discusses patient care management and the role of the head nurse in this area. This could be considered the highlight of the book. Having dealt comprehensively with administration, the author emphasizes the total needs of the patient very adequately. For its very fine presentation of current trends in nursing, this section is highly recommended.

Part III, dealing with the responsibility for staff development, is informative and offers detailed direction for achieving objectives. This is one of the difficult areas confronting the head nurse. Suggested guidance should prove valuable. The author has provoked a new interest here, and the head nurse is made aware of the challenge. Under this plan of development the end results should be a well-organized staff and improved patient care. Nursing endorses this philosophy.

Principles of Chemistry by Joseph H. Roe, Ph.D. 388 pages. St. Louis: The C. V. Mosby Company. Ed. 9. 1963.

A Laboratory Guide in Chemistry by Joseph H. Roe, Ph.D. 262 pages St. Louis: The C. V. Mosby Company. Ed. 4. 1963.

Reviewed by Mrs. Nancy Mackenzie, Ph.D., chemistry lecturer, Kingston, Ont.

The textbook, in the opening chapters, clearly and concisely outlines the basic principles of inorganic and organic chemistry, providing a sound foundation for an understanding of the biochemical and physiological aspects that follow. Complete comprehension of the contents of this book would provide the student nurse with a knowledge of chemistry adequate for degree qualification and necessary for postgraduate advancement in biochemistry and physiology.

The opening chapters deal with inorganic chemistry. The student should find them informative and adequate. It is an excellent idea to introduce the structure of the atom early in the course since it enables the instructor to present the relationship between chemical structure and behavior at an earlier stage.

In order that a student may be fully aware of the importance of digestion and metabolism, organic chemistry must be studied. The presentation must be simple enough for a student to grasp readily. This book provides an excellent introduction. The chapters on carbohydrates, fats and proteins help the student to understand their importance "to all living things."

The study questions are helpful to both student and teacher in reviewing progress. The textbook and the laboratory notebook, used together, form an ideal combination.

An excellent manual to aid students in their practical work. It should be used in conjunction with the above textbook. The experiments cover a large field in inorganic and organic chemistry and are presented clearly and concisely. The students have a page at the end of each experiment on which to note their observations and to answer specific questions relating to the subject under study.

New experiments have been introduced in this edition, such as quantitative analysis, enabling students to realize the importance of detail and precision in all practical work.

Newer Dimensions of Patient Care. Part 2. Improving Staff Motivation and Competence in the General Hospital by Esther Lucille Brown, Ph.D. 194 pages. Russell Sage Foundation, New York. 1962.

Reviewed by Mrs. Jeanie S. Tronningsdal, director of nursing, Foothills Provincial General Hospital, Calgary, Alta.

"This is the second of three discussions concerned with psychosocial and cultural aspects of patient care in general hospitals."

How can patient care be improved? The basic question dealt with in this book

> becomes one of attempting to see whether the psychosocial as well as the economic needs of staff and the objectives of the institution can be harmonized sufficiently to foster better utilization of the hospitals' human resources.

In five chapters the author explores this question from various approaches and then summarizes her suggestions in two final chapters under the heading "Effecting Change." Herewith are some of the highlights.

She states that the psychological and social needs of staff more than the economic needs of personnel require careful attention. She points out that small work groups contribute to staff security, support, and opportunity for social contacts; that they constitute the informal organization of the institution; that they are capable of setting work norms and exercising considerable indirect power over administration. On the other hand, the bureaucratic or hierarchical forms of organization usually found in hospitals pose serious questions about how operational efficiency can be achieved while the basic psychological needs of the staff are protected. Under such a type of organization, communication and coordination of patient care is seriously impeded because a pattern that fosters distinct separateness among the professions is almost certain to reduce lateral communication.

Hospitals have tended to rely upon the hope that improvement in salaries, fringe benefits and physical working conditions

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would result in higher levels of motivation. Such emoluments may improve morale but they provide no reward to the individual for excellence of work and hence little incentive to increase productivity. Motivation presents a problem that is often scarcely less important than that of shortages of staff.

The comments in the above paragraphs are representative of the material covered in the first five chapters of this book. It should be sufficient to whet the appetite of readers to explore it in detail and to study the suggestions to effect change that Dr. Brown makes in the two concluding chapters.

To any nurse charged with the responsibility of directing staff, I would commend this book as one that gives a fresh approach and timely solutions to some of the daily problems encountered in providing improved patient care. I would also urge that it be passed along to administrative and medical colleagues for their deliberation and guidance. Their cooperation is imperative if the nurse is to effect successfully the changes that are proposed.

Operating Theatre Technique by Raymond J. Brigden, S.R.N. 580 pages. E. & S. Livingstone Ltd., Edinburgh and London. 1962.

Reviewed by Sister Paul of the Cross, Charlottetown Hospital, Charlottetown, P.E.I.

This book is primarily designed for use by nurses, technicians, medical students, house surgeons and others associated with the operating theatre, as a supplementary and reference book for theatre techniques. It contains interesting, informative material and beautifully clear illustrations. Most phases of operating room technique are considered.

The first sections present the physical layout of a theatre unit; illustrations and references related to operating room facilities, safety measures; suggested procedures for ensuring a safe, comfortable environment. Operative procedures are discussed according to body systems under the heading of definition; method of posturing the patient; outline of procedure that answers the question: "What is to be expected at this operation?" The latter is presented in a manner that paints a vivid mental picture. Much emphasis is put on general and orthopedic surgery. Open heart surgery is not listed.

Most of the material is familiar; all sections contain much detail. References listed are from books and journals published in England. Two sections that merit special praise are: radioactive materials; static electricity. They present very valuable information. However, there is one chapter on sterilization in which the methods advocated are obsolete and not consistent with the practices used in Canadian hospitals.

The appendix contains a complete display of instruments used in any well-equipped operating theatre. This section is clearly illustrated, very descriptive and greatly enhances the usefulness of the book.

The author has presented his material in an excellent fashion. It is recommended

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as reference reading for the staff of the operating theatre in order to provide better patient care and to ensure safe practices in the operating room.

Orthopaedic Nursing by Mary Powell, S. R.N., M.C.S.P. 516 pages. The Macmillan Company of Canada Limited, 70 Bond St., Toronto. Ed. 4. 1962.
Reviewed by Dorothy Cummings, Polio Clinic and Health Centre, Fredericton, N.B.

This revised edition brings to nurses in orthopedic units modern principles and techniques for the care of handicapped and disabled persons. It teaches them how to keep their patients comfortable by knowing the proper way to apply splints, traction, and other apparatus so that the function is fulfilled. It presents total patient care including admission, pre- and postoperative care, nutrition, prevention of complications and deformities. It is generously illustrated. There is suggested instruction that can be given to the patient on discharge from hospital.

Since orthopedic work is concerned with the form and function of the body, each nurse in this field should have a knowledge of normal position, structure, and function of bones, joints, and muscles. The text gives us this information as well as good body mechanics. There are 31 chapters covering all phases of orthopedic treatment for congenital and acquired deformities; fractures and other injuries; deformities caused by organic diseases and metabolic disorders. There is a useful discussion on operating room technique and detailed instruction regarding plaster casts — their application, and the care of the patient.

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Registered Nurses for 85-bed General Hospital. Salary $300-$354/m. Differential for experience and advanced preparation. Accommodation available in modern residence. Apply to: Director of Nursing Service, St. Joseph's General Hospital, Vegreville, Alberta. 1-89-1

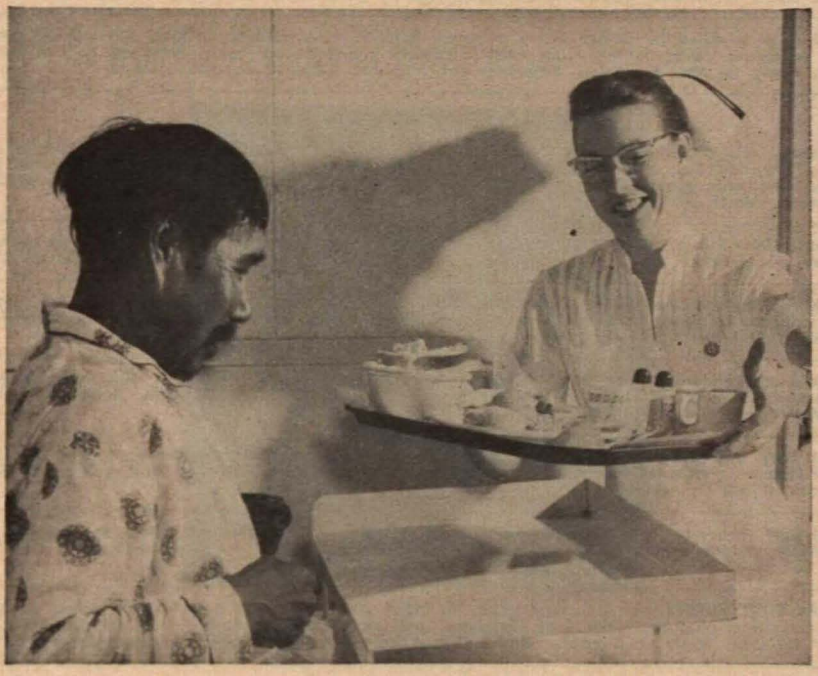
Registered Nurses for new 50-bed Auxiliary Hospital. Basic salary $325/m with $15/yr. for 3 years. Past service recognized. AARN policy, M.S.I. and Blue Cross. Must live out. Apply: Matron, Wainwright-Provost Auxiliary Hospital, Wainwright, Alberta. 1-94-1A

Registered and Graduate Nurses for 50-bed Auxiliary Hospital at Westlock, 50-mi. north of Edmonton. Salary in accordance with AARN. 8-hr. day, 5-day wk., statutory holidays, 3-wk. vacation after 1 year. Duties to commence early 1964. Applications to: J. E. Phillips, Administrator, Westlock, Alberta. 1-95-2

General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $300-$350 for Alberta registered; $290-$340 for non-Alberta registered. New separate residence, excellent personnel policies & working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

NURSING WITH

Medical Services Directorate



REGISTERED HOSPITAL NURSES
PUBLIC HEALTH NURSES
AND
CERTIFIED AUXILIARY NURSES

For service to Indians across Canada, Eskimos and the population of the Yukon and Northwest Territories.

Those interested in positions at the following locations should write to: Fisher River Hospital, HODGSON, MAN.; Miller Bay Hospital, PRINCE RUPERT, B.C.; Moose Factory Hospital, MOOSE FACTORY, ONT.; Norway House Hospital, NORWAY HOUSE, MAN.; Sioux Lookout Indian Hospital, SIOUX LOOKOUT, ONT.; Nanaimo Indian Hospital, NANAIMO, B.C.

Information on these and other positions is available from Medical Services Directorate, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

Director, Personnel Services,

DEPARTMENT OF NATIONAL HEALTH AND WELFARE, OTTAWA

General Duty Nurses. Starting salary: $300 per mo., 40 hr. work wk. Room, board & laundry available, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

General Duty Nurses (2) for modern 25-bed hospital on Highway No. 12. Salary range $340 to $385. New staff residence. Full maintenance $35, personnel policies include Blue Cross, M.S.I. and pension plans. 21 days' vacation per year, plus statutory holidays. Apply to the: Director of Nurses, Municipal Hospital, Coronation, Alberta. 1-25-1

REGISTERED NURSES for new active 30-bed hospital located 20-mi. from Edmonton on Jasper Highway. Basic salary $300 with credit for experience. Room and board in modern nurses' home at $35/m. AARN personnel policies. Apply to: Director of Nurses, Municipal Hospital, Stony Plain, Alberta. 1-99-1

NURSES fully qualified for 30-bed active treatment hospital. New hospital building and recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, Municipal Hospital, Bassano, Alberta. 1-5-1

BRITISH COLUMBIA

Supervisors, male or female (Sunny Okanagan needs you) for 105-bed modern, accredited hospital with a building program. Baccalaureate degree preferred with supervisory experience. RNABC personnel policies in effect. Residence available. Enjoy the opportunities and advantages of a resort town. Apply to: Director of Nursing, Vernon Jubilee Hospital, Vernon, British Columbia. 2-75-2

Psychiatric Unit: Nurses, preferably with P.G., for small, new unit in General Hospital. Services coordinated with new mental health clinic. Apply: Director of Nursing, General Hospital, Kelowna, British Columbia. 2-34-1

Head Nurse, male or female, for active Operating Room Unit. Postgraduate training required. Good personnel policies; residence accommodation available (female). Apply to: Director of Nursing, Trail-Tadanac Hospital, Trail, British Columbia. 2-72-1

Registered or Graduate General Duty Nurses for active 25-bed hospital. Salary B.C. registered $320 to start. Unregistered $305. RNABC personnel policies in effect, nurses' residence available. Apply: Administrator, Lady Minto Hospital, Ashcroft, British Columbia. 2-4-1

General Duty and O.R. Nurses with postgraduate course or equivalent experience required for 146-bed General Hospital. Personnel policies in accordance with RNABC. Apply: Director of Nursing, General Hospital, Chilliwack, British Columbia. 2-13-1

General Duty Nurses for active 30-bed hospital. RNABC policies and schedules in effect also Northern allowance. Accommodations available in residence. Apply: Director of Nursing, General Hospital, Fort Nelson, British Columbia. 2-23-1

GENERAL DUTY NURSES with B.C. registration for active 200-bed General Hospital with School of Nursing. Large expansion program under way. Personnel policies, including salary, in accordance with RNABC contract for 1964. Apply to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia. 2-32-1

General Duty Nurses for fully accredited 82-bed hospital in northwestern B.C. 1963 salaries; B.C. Registered $335 - $402; Non-registered $320. Room and board $50/m, 10 statutory holidays, 1-½-day sick leave, 4-wk. vacation, superannuation and Medical Plan coverage. Fare advanced if required. Apply to: Director of Nursing, General Hospital, Kitimat, British Columbia. 2-36-1

General Duty Nurses in all departments for modern hospital in a very active community. Starting basic salary: $320 for B.C. Registration and $305 for non B.C. Registered. Allowance made for qualifications and experience. RNABC personnel policies in effect. Planned rotation. Rooms available in nurses' residence: $26/m. Apply to: Director of Nursing, Prince George Regional Hospital, Prince George, British Columbia. 2-57-1

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—B.C. registered $335-$402, non-registered $320. Newly furnished residence with T.V. Good social activities, including bowling, curling, tennis and year-round swimming. Full personnel benefits including travel allowance. Apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia. 2-58-2

General Duty Nurses for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn and Hudson Bay Glacier. Initial salary $335, maintenance $50, 40-hr. 5-day wk., 4-wk vacation. Boating, fishing, swimming, golfing, curling, skating, skiing. Comfortable nurses' residence, rail fare advanced if necessary. Apply: Sacred Heart Hospital, Smithers, British Columbia. 2-73-13

General Duty, Operating Room & Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $320-$387. Credit for past experience & postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. 2-73-13

Graduate Nurses and Certified Nursing Assistants for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. registered $320 with regular increments; unregistered $305; Nursing Assistants $214-$246. Board and room $25 per mo., 28-day vacation plus 10 statutory holidays after 1 year. Superannuation and medical plans. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia. 2-2-1

General Duty Nurses (2); Certified Nursing Aide (1) for 45-bed hospital. RNABC policies in effect. Friendly city with many social activities — fishing, boating, swimming, golfing, curling, skating and skiing. Apply: Director of Nursing Services, Fernie, British Columbia. 2-22-1

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic rate $320/m with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

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APPLICATION FOR GENERAL DUTY POSITIONS INVITED

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THE DIRECTOR OF NURSING

555 UNIVERSITY AVENUE, TORONTO, CANADA

Graduate Nurses for General Duty in medicine, surgery, obstetrics, pediatrics and operating room in new, modern 188-bed hospital in city (20,000) on east coast of Vancouver Island. Personnel policies in accordance with RNABC policies. Starting salary for R.N. — $332 approx./m. Apply to: Director of Nursing, Regional General Hospital, Nanaimo, British Columbia. 2-46-1

Operating Room, Obstetrical and General Duty Nurses, British Columbia registered, for modern 450-bed acute General Hospital, located on South Vancouver Island. Basic salary $320, credit for experience & postgraduate preparation, personnel policies in accordance with RNABC. For particulars write to: Director of Nursing Service,St. Joseph's Hospital, Victoria, British Columbia. 2-76-5

Nurses two for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing. Community Hospital, Grand Forks, British Columbia. 2-27-1

MANITOBA

Instructors in concurrent teaching program for Fundamentals in Nursing, Medicine-Surgery, Obstetrics, Pediatrics, Psychiatry. Salary in accordance with qualifications and experience. Degree preferred. Modern 700-bed hospital, with excellent clinical facilities. Please apply to: Sister A. Fleury, Director, St. Boniface General Hospital School of Nursing, St. Boniface 6, Manitoba. 3-74-1

Registered Nurse for 17-bed General Hospital near Brandon, Manitoba. Starting salary $330, 40-hr. wk., 3-wk. vacation after 1-yr. service, 10 statutory holidays. For further informaiton, please apply to: Miss O. M. Purdy, Matron, Boissevain, Morton and Minto Memorial Hospital, Box 126, Boissevain, Manitoba 3-11-1

Registered Nurse with some experience for the position of Matron, in a rural community hospital. Starting salary $375/m, semi-annual increments of $15/m., very good working conditions. Room and board at the hospital, $50/m., Apply: Secretary-Treasurer, Fisher Branch Medical Nursing Unit, Fisher Branch, Manitoba. 3-23-1

Registered Nurses (3) for 20-bed hospital in Southwestern Manitoba. Salary $330 with 4 increments of $15, 40-hr.-wk., and 10 statutory holidays plus those declared by the town. Meals available. Apply to: Mrs. R. C. Steeves, Matron, Wilson Memorial Hospital, Melita, Manitoba. 3-37-1

Registered Nurses and Licenced Practical Nurses for 17-bed hospital in western Manitoba. 40-hr. wk., starting salary for R.N. $330/m, and for L.P.N. $225/m. For further particulars and application forms please contact: Mrs. A. M. Stitt, Director of Nurses, Rossburn Medical Nursing Unit, Rossburn, Manitoba. 3-49-1

Registered and Practical Nurses (immediately) for 18-bed hospital at Vita, Man., 70-mi. from Winnipeg. Starting salary, R.N. $330 - L.P.N. $225, with allowance for experience. Daily bus service. 40-hr. wk., full maintenance available for $50/m. Apply to: Matron, District Hospital, Vita, Manitoba. 3-68-1

Registered Nurses General Duty (2) for modern 10-bed hospital. Salary $320-$370, 40-hr.wk., accommodation available for $45/m. Good personnel policies. Apply: Matron, Benito Hospital, Benito, Manitoba. 3-6-1

General Duty Nurses (3) for new 85-bed hospital. Good salary and generous personnel policies. Apply: Director of Nursing, Portage Hospital District No. 18, Portage La Prairie, Manitoba. 3-45-1

NORTHWEST TERRITORIES

DIRECTOR OF NURSING SERVICE: Applications are invited for the position of Director of Nursing at the 44-bed Stanton Yellowknife Hospital. This prosperous mining community in Canada's exciting Northland offers a wide variety of sports and activities for your fun and pleasure. There is a suite available in the nurses' residence, with all modern conveniences. Descriptive literature and personnel policies supplied on request. Apply stating qualifications and supervisory experience, to: Administrator, Stanton Yellowknife Hospital, Box 10, Yellowknife, N.W.T. 12-11-1

NOVA SCOTIA

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia. 6-21-1

ONTARIO

DIRECTOR OF NURSING: Applications are invited for the position of Director of Nursing in 32-bed, modern General Hospital, 250-mi. east of Port Arthur. Operating Room experience essential. Excellent accommodation, pension plan, group insurance, etc. Salary commensurate with qualifications and experience. Apply to: Administrator, General Hospital, Manitouwadge, Ontario. (Phone 826-3251). 7-74-1

Lecturer in Nursing: School of Nursing, McMaster University invites applications from persons qualified in either the field of Medical-Surgical or Maternal and Child Care Nursing. Positions open in 1964-65. Apply giving qualifications and references to: Director, School of Nursing, McMaster University, Hamilton, Ontario. 7-55-15

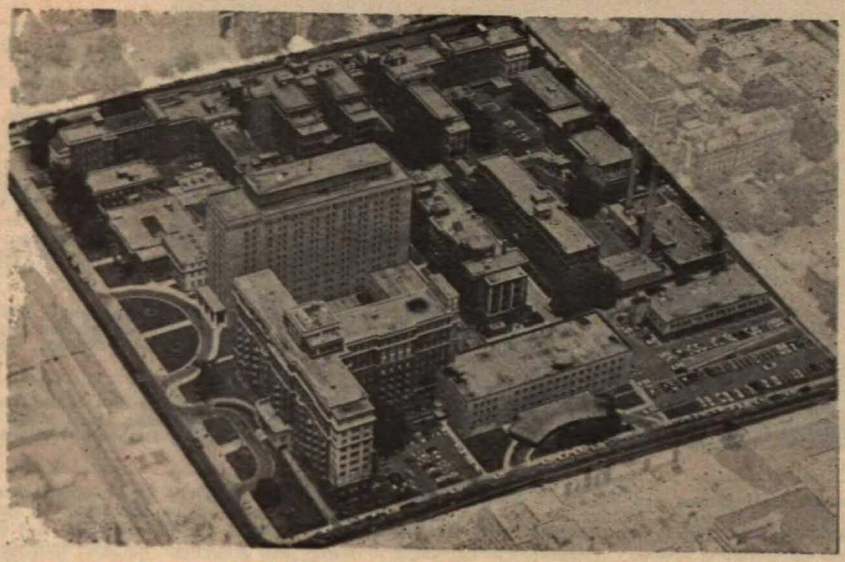
Registered Nurses for 100-bed General Hospital situated in Northern Ontario. Good personnel policies including O.H.A. pension plan. Salary scale as applicable in district. Residence accommodation if desired. For particulars, apply to: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses for 34-bed hospital, min. salary $340, 3-wk. vacation with pay, sick leave after 6-mo. service. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

REGISTERED NURSES for small hospital. Good salaries and personnel policies. Accommodation available in modern nurses' residence. For further details apply: Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario. 7-86-1

Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,000. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone 826-3251. 7-74-1A

TORONTO GENERAL HOSPITAL



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Planned Orientation Programme — Inservice Educational Programmes
Opportunity to gain additional knowledge in specialized fields of nursing
Excellent personnel policies
Salaries commensurate with prevailing current salaries in Metropolitan Toronto

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THE COLLINGWOOD GENERAL AND MARINE HOSPITAL

Invites applications for

Registered Nurse for Night Supervisor
Central Supply Room Supervisor
Pediatric Ward Head Nurse

Registered Nurses and Registered Nurse Assistants for General Duty in this modern 126-bed hospital. We have recently completed our new extension and require additional staff. Opportunities in all departments. The Town of Collingwood on beautiful Georgian Bay offers the finest in winter and summer sports.

For further particulars write:

DIRECTOR OF NURSING SERVICES,
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Collingwood, Ontario.

COURSES FOR R.N.'S N.Y. POLYCLINIC MED. SCH & HOSP. — in heart of Manhattan — 6-mo. courses in: **O.R. NURSING, OPD. NURSING, MED.-SURG. NURSING.** Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & Monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK. 15-33-24

Registered Nurses and Certified Nursing Assistants for well-equipped 75-bed hospital in progressive town of 6,500, situated midway between Winnipeg and the Canadian Lakehead. Reg.N., $319 and Cert.N.Ass'ts, $224/m with single room accommodation available in modern nurses' residence. Excellent personnel policies. For further information, please phone or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

Registered Nurses and Registered Nursing Assistants for 100-bed General Hospital — La Verendrye Hospital, Fort Frances, Ontario — approved by Canadian Council on Accreditation; eight doctors on the Medical Staff. Reg.N. — 1 as Supervisor and Head Nurse for Operating Room and Central Service Room, 3 or 4 Reg.N. for Medical and Surgical and Pediatric wards. R.N. salaries are as recommended by the RNAO policies. Good working conditions—40-hr. wk., 5 days per wk., 9 statutory holidays, sick leave benefits, compassionate leave and 3-wk. vacation with pay after one year. R.N.A. salaries and statutory holidays according to the union agreement. R.N.A. for General Staff and the C.S.R. The town is situated on the American border across the river from International Falls, Minnesota. It is noted for tourist attraction, especially fishing and boating. There is also a nine-hole golf course. Apply: La Verendrye Hospital, Fort Frances, Ontario. 7-46-1

Registered Nurses and Registered Nursing Assistants for 95-bed General Hospital in attractive town on Lake Huron. Starting salaries commensurate with experience and qualifications. Residence accommodation available. Benefits similar to those provided in most hospitals in Ontario. Apply to: Director of Nursing, Alexandra Marine and General Hospital, Goderich, Ontario. 7-51-1

Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $340 and $235 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Assistance with transportation can be arranged. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries $335 and $225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

Registered Staff Nurses and Registered Nursing Assistants for 200-bed hospital. Well defined personnel policies include 5-day wk., 8 statutory holidays and pension plan. Home of the Shakespearian Festival. Apply: Director of Nursing, Stratford General Hospital, Stratford, Ontario. 7-124-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only $45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range $350 - $375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered Nurses for General Duty in all departments including premature and new-born nursery, Isolation, Emergency, Recovery Room, and Intensive Care Unit. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty for well-equipped 42-bed General Hospital located in area known for its wealth of natural resources. The sportsminded person has unlimited activities to enjoy. Salary range $325 to $365 with increment for experience. Excellent personnel policies. Accommodation available in well furnished nurses' residence. For further information please phone or write: The Director of Nursing, General Hospital, P.O. Box 909, Sioux Lookout, Ontario. 7-119-1

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $325 per mo.** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario. 7-127-4

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

GENERAL DUTY REGISTERED NURSES for 200-bed hospital situated in a beautiful residential town on the shores of Lake Temiskaming. Starting salary $340, good personnel policies including 40-hr. wk., O.H.A. pension plan, etc. Accommodation available in residence if desired. For particulars apply to: Director of Nursing, Misericordia Hospital, Haileybury, Ontario. 7-54-1

General Duty Nurses for an accredited 66-bed hospital. Starting salary: $325. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $315-$345 per mo., Graduates $250 $295; 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $325/m basic salary. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment. 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Operating Room Nurse (immediately) for Active General Surgery, good experience, 75-bed hospital with separate residence. Excellent personnel policies. Further information available from the Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

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In this modern 400-bed non sectarian hospital in Administration, Teaching, Staff Nursing, Certified Nursing Assistants also required. Openings in Psychiatry, Pediatrics, Obstetrics and Medicine and Surgery. Excellent personnel policies. Bursaries for post-basic courses in Teaching and Administration.

For further information, please write:

Director of Nursing, JEWISH GENERAL HOSPITAL, 3755 Cote St. Catherine Rd., Montreal, Que.

THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL,
WINNIPEG 3, MANITOBA.

OPERATING ROOM NURSE — Applications are invited for the position of Operating Room Nurse in 32-bed modern General Hospital, 250-mi. East of Port Arthur. P.G. course desirable but not essential. Excellent accommodation in self-contained apartment, pension plan, group insurance, etc. Salary commensurate with qualifications and experience. Apply to: Administrator, General Hospital, Manitouwadge, Ontario. (Phone 826-3251). 7-74-1B

Public Health Nurses (Qualified) for generalized program, by Stormont, Dundas and Glengarry Health Unit located in the Seaway Valley area. Minimum salary $4,000. Annual increment. Allowance for experience. 5-day wk. Employer-shared (50-50) group insurance, portable OMERS pension plan, Ontario Hospital Insurance and P.S.I. coverage (medical, surgical and obstetrical plan). 3-wk. vacation, cumulative sick leave credits, one-half paid as bonus upon leaving after 3-yr. service. Generous car allowance. Reply in writing to: Dr. John A. Thomson, Medical Officer of Health, Box 1058, Cornwall, Ontario. 7-34-5

Public Health Nurse (Qualified) for generalized program. Salary range: $4,000-$5,000. Car provided, pension plan, attractive personnel policies. Cost of travelling to Kenora provided. Apply to: Dr. P. F. Playfair, M.O.H., Northwestern Health Unit, Box 250, Kenora, Ontario. 7-64-3

Public Health Nurses (Qualified). Salary range $3.850 - $4,600, required in a generalized program in rural and semi-urban area adjacent to Metropolitan Toronto. Excellent working conditions including pension plan, group insurance, and transportation arrangements. Write: Dr. R. M. King, York County Health Unit, 64 Bayview Avenue, Newmarket, Ontario. 7-84-2

Public Health Nurse for Dufferin County Health Unit. Annual increment, fringe benefits in effect, generalized program. Apply to: Mr. W. H. Hunter, Secretary, Dufferin County Board of Health, Orangeville, Ontario. 7-90-1

PUBLIC HEALTH NURSE REQUIRED FOR NIPIGON-RED ROCK AREA. Applicant must be registered in Ontario and hold a certificate in Public Health Nursing. Attractive salary schedule. Car will be supplied. Numerous benefits. Apply in writing to: Dr. W. C. MacPherson, Director, Port Arthur and District Health Unit, 93 Balsam Street, Port Arthur, Ontario. 7-106-3

STAFF NURSES and O.R. and OBSTETRIC NURSES for 220-bed accredited hospital with School of Nursing. 1963 salary scale $305-$345. Postgraduate premium $320-$360. Usual personnel benefits, plus proximity to Ottawa, Montreal and Northern New York State. Apply: Acting Director of Nursing Service, Cornwall General Hospital, Cornwall, Ontario. 7-34-1

Staff Nurses for all nursing units of a 325-bed, fully accredited General Hospital located in downtown area. Orientation and in-service program. Rotating hours of duty. Attractive salary & fringe benefits. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 150-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda. 13-1-1B

QUEBEC

Assistant Head Nurses and Certified Nursing Assistants for 60-bed children's orthopedic hospital. Excellent personnel policies. Apply: Miss Flora M. Lamont, Reg.N., Administrator, Shriners Hospital for Crippled Children, 1529 Cedar Avenue, Montreal 25, Quebec. 9-47-42

Registered Nurses and Certified Nursing Assistants for 110-bed hospital for tuberculosis and other chest diseases. In the heart of the Laurentian Mountains, 55 miles north of Montreal. Apply: Director of Nursing, P.O. Box 1,000, Ste Agathe des Monts, Quebec. 9-57-1

SASKATCHEWAN

Registered Nurses (2) Salary $330/m with a deduction of $31 for room and board. Residence on grounds. Apply: Mr. Nathan M. Graham, Secretary, Climax-Bracken-Union Hospital, Climax, Saskatchewan. 10-17-1

Registered Nurses (3) for new 19-bed hospital, located in Hafford, a growing modern town. Starting salary according to SRNA recommendations, dependent on qualifications and experience. Modern nurses' residence and good personnel policies. Apply to: or Phone on Reverse No. 48 or No. 87 — Director of Nursing, Mrs. Sophie Tkachuk or Secretary Manager, Mr. Eugene Michayluk, Union Hospital, Hafford, Saskatchewan. 10-43-1

General Duty Nurses, Saskatchewan registered, for 100-bed General Hospital. Salary based on experience, with recognition for P.G. courses and University training. Good personnel policies, residence accommodation and meals if desired. Apply to: Director of Nurses, Union Hospital, Weyburn, Saskatchewan. 10-135-2

U.S.A.

Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula yet only 20-min. from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect, OXford 7-4061 or write: Director of Personnel, Peninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $325 monthly with annual increments for 4 years to $365.

Until registration in Ontario is established — $300.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO

THE SARNIA GENERAL HOSPITAL

Offers excellent opportunities for

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS

Sarnia is an industrial city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

The Hospital is modern, fully approved (JCAH), and has recently been expanded to 350 beds.

Positions are available in all services.

Salary scale with annual increments to the maximum. Additional salary allowance for two years or more acceptable experience or postgraduate certificate. Benefits include pension plan, 40-hour week, regular rotation of shifts with premium pay for evenings and nights.

Apply:

PERSONNEL DIRECTOR,
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $395 with automatic increases to $455 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from $380-$450, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — all services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation Hospitals, San Francisco 15, California. 15-5-7

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Registered Nurses (Ventura County, Southern California, an ideally located, rapidly expanding area has positions open) 350-bed hospital, salary $384-$466, compensation for experience, Nurses' residence, near urban shopping area. Write: Personnel Department, Courthouse, Ventura, California. 15-5-53

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

General Duty Staff Nurses for 450-bed, fully approved hospital. Salary range per mo: Day Duty, $438-$458. P.M. and night duty, $448-$468. 40-hr. wk. Paid vacation. 7 paid holidays per yr. Accumulative sick time based on length of service. Liberal hospitalization plan. Nurses' residence. Rooms at reasonable rates. Registration or permit to work in California required. Address applications to: Chief Nurse, Southern Pacific Railroad Hospital, San Francisco, California. 15-5-6B

(a) **Operating Room Nurses** (experienced); basic salary $385 with good financial reimbursement for call. (b) **Obs. Nurses** $385 basic salary with $20 differential for 3-11 or 11-7 shifts. (c) **General Duty Nurses** $375 basic salary, $20 differential for 3-11 or 11-7 shifts. Apply: Director of Nurses, General Hospital, Eureka, California. 15-5-14

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Staff Nurses for 100-bed County Hospital located in the progressive San Joaquin Valley. Salary: $395-$458/m. Starting salary depends on experience. $10 shift differential for evenings and nights. Occasional promotions to Head and Supervising positions. Liberal fringe benefits. Modern nurses' residence at nominal cost. Call or write: Director of Nurses, Tulare County General Hospital, Tulare, California. 15-5-44A

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for various departments including surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases and fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

Executive Director generalized public health nursing agency. Potential for program expansion in rapidly growing community 45 minutes from NYC. Staff 8 full time, 5 relief nurses. Master's degree, administrative ability; experience required, salary open. Send résumé to Mr. Charles H. Ulrich, Chairman, Personnel Staff Committee, Visiting Nurse Association, 60 Guernsey Street, Stamford, Connecticut. 15-7-4

General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida. 15-10-3

REGISTERED NURSES: for 75-bed, air-conditioned hospital, growing community. Starting salary $330-$365/m, fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization, 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1

Staff Nurses (All Areas) Orientation and staff development programs, "nurse-saving" equipment, challenging working environment, individualized living accommodations in new air-conditioned cottages. Opportunity to participate in nursing practice of the finest quality in our 200-bed General Hospital, located along Lake Michigan shoreline, 30 mi. from Chicago. Starting salaries $390-$410 plus $30 differential for 3-11 and 11-7. Write: Director of Nursing, Highland Park Hospital, Highland Park, Illinois, for detailed brochure. 15-14-3

Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth B. Kennedy, R.N., Director of Nursing, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

HUMBER MEMORIAL HOSPITAL

HOSPITAL —

Newly expanded 350-bed hospital. Progressive patient care concept.

HOUSING —

Furnished apartments available at subsidized rates.

JOB SATISFACTION —

High quality patient care and friendly working environment, personal recognition and professional development.

You are invited to enquire concerning employment opportunities to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL,
200 Church Street, Weston, Ontario - Telephone 249-8111 (Toronto)

THE SCARBOROUGH GENERAL HOSPITAL

A new modern hospital located 10 miles from downtown Toronto invites applications from:

REGISTERED NURSES
REGISTERED NURSING ASSISTANTS

Opportunities are offered in Supervisory, Head Nurse and General Duty positions. Services are offered in Medicine, Surgery, Obstetrics, Pediatrics, Emergency and Intensive Care Units.

Salaries commensurate with prevailing current salaries for Nurses in Metropolitan Toronto and adjustable with experience and educational qualifications.

Progressive Personnel Policies, Pension Plan, Orientation and In-service Program.

For further information write to:

DIRECTOR OF NURSING,
SCARBOROUGH GENERAL HOSPITAL, SCARBOROUGH, ONTARIO.

REGISTERED NURSES REQUIRED

For General Duty in modern 18-bed private Hospital in Iron mining town, 140 miles north of Sault Ste. Marie, Ontario.

SALARY RANGE $320 MINIMUM TO $360 MAXIMUM

Allowance for experience. Board and room available at $20 per month. Transportation allowance up to $50 after 6 months.

Apply:

SUPERINTENDENT OF NURSES, LADY DUNN HOSPITAL, WAWA, ONTARIO.

REGISTERED NURSES — Openings on all shifts in delivery and operating rooms, nurseries, special care and post-partum units in 175-bed, JCAH fully accredited maternity hospital affiliated with Harvard Medical School. 5-day, 40-hr. wk., with good starting salaries and liberal differentials for night and evening duty. Excellent advancement opportunities, benefits, and personnel policies, plus all the personal and professional advantages of a research and teaching institution in a major educational, social and cultural center. Housing available in convenient, attractive hospital-owned apartments. For information, please write to: Samuel L. Barres, Personnel Director, Boston Lying-in Hospital, 221 Longwood Avenue, Boston 15, Massachusetts. 15-22-4B

Staff Nurses 380-bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks., 5 yrs. — 4 wks. Active in-service pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611. 15-32-3

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of Nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $387. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon. 15-38-1

Clinical Instructors (2) Fundamentals of Nursing and Obstetrical Nursing. 20 students enrolled annually. Bachelor's degree required, Master's preferred. Salary $450, or better, depending upon qualifications. Good personnel policies. Write to: Director of School of Nursing, Methodist Hospital, Mitchell, South Dakota. 15-41-1

Staff Nurses (All Clinical Services) Base salary $350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus. Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

ASSOCIATE DIRECTOR OF DEPT. OF NURSING (IMMEDIATELY). Salary range $6,432-$8,400, depending upon experience. Master's Degree required. Assists with the administration of all functions of the Department of Nursing in a large general teaching hospital center (approximatively 1,300 beds) which includes: two general hospitals, a rehabilitation hospital, a sanatorium hospital, a sonatorium section and outpatient clinic. Directly responsible for the administration of nursing service in one of the general hospitals (approximately 500 beds) and the rehabilitation hospital(approximately 100 beds); Consults and plans with the director of the department of nursing in the administration of nursing service for the entire department of nursing in the hospital division and relieves the director when necessary. Liberal benefits. Apply: Post Office Box 67, Medical College of Virginia, 12th and Broad Streets, Richmond 19, Virginia. 15-47-2

HEAD NURSE for Orthopedic and Neurosurgery nursing unit, total of 30 beds. Nursing unit exceptionally well designed and equipped. New Teaching and Research University Hospital. Beautiful location on campus. Liberal fringe benefits including free tuition class (6 credits) after 6 monts full time employment. Salary range $443-$539. Starting salary commensurate with experience and/or education. Applicant should have had 1 year experience in head nursing preferably on an orthopedic or neurosurgery unit. Apply: Director of Nursing Services, AA 310 University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2E

Staff Nurses — University Hospital wants you if you want a challenging and rewarding position in a modern expanding 320-bed teaching and research hospital located on campus. Salary $380-$442/m. Opportunities in clinical research, premature center, open heart surgery, physical medicine, in addition to the general services. Liberal benefits including tuition free courses after six months. Contact: Director of Nursing Services, University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2D

MANITOBA

General Duty Registered Nurse (1) for 24-bed hospital, 1963 salary range $330-$370. Also **Licensed Practical Nurse** (1) salary range $220-$260, 40-hr. wk., vacation pay, 10 statutory holidays, group life, pension and medical plans in effect, room and board $45. Apply to: Mrs. M. Gibson, Administrator, Treherne Hospital District No. 19A, Treherne, Manitoba. 3-66-1

ONTARIO

Registered Nurses and Registered Nursing Assistants for 29-bed, active treatment hospital. Starting salaries $340 and $215 respectively with annual increments; living accommodation $45/m, 40-hr. wk., 3-wk. vacation after 1 year; 8 statutory holidays and other fringe benefits. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario. 7-77-1

REGISTERED NURSES FOR GENERAL DUTY

In small-sized General Hospital accredited. Located in attractive community 1 hour from Ottawa. Good personnel policies.

Apply:

Superintendent,
KEMPTVILLE DISTRICT HOSPITAL,
Kemptville, Ontario.

REGISTERED NURSE

for

110-bed "HOME FOR THE AGED" with 50-bed bed-care wing. Located on Grand River, Niagara Peninsula within 1 hour's travel to Hamilton, Niagara Falls and Buffalo, N.Y. Modern staff quarters optional.

For full particulars apply:
SUPERINTENDENT
stating qualifications, experience and remuneration
GRANDVIEW LODGE
Dunnville, Ontario

BERWYN MUNICIPAL HOSPITAL

Requires Registered Nurses for General Duty — Salary $300 to $345 M.S.I.

Apply to:
DIRECTOR OF NURSING
BERWYN MUNICIPAL HOSPITAL - BERWYN, ALBERTA

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $375 - $462 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION No. 64:1

POSITIONS OPEN — REGISTERED NURSES

Starting Salary $330 per month - Allowance for experience - Enquiries invited - Personnel Policies on request - 40 Hour Week - 9 statutory Holidays - Room and Board - Nurses' Residence $45 per month
New Hospital to be completed very soon

Apply to: Mrs. G. AUGER
DIRECTOR OF NURSING, LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO

SUPERINTENDENT OF NURSES

Required by 18-bed Private Hospital. Ontario registration required.
Registered Nurse with supervisory experience or experience as Superintendent of small hospital would fill requirements. Two room apartment with bath and all meals supplied for $20 per month. Four weeks annual vacation per year, eight statutory holidays, hospitalization, medical-surgical and Group Insurance. Moving expenses up to $50 refunded following six months employment. Salary scale will be forwarded following application.

Apply to:
MRS. V. M. SWITZER, SECRETARY,
BOARD OF DIRECTORS, LADY DUNN HOSPITAL, WAWA, ONTARIO.

ASSISTANT DIRECTOR OF NURSING SERVICE

Wanted for McKellar General Hospital. An active treatment hospital of 380 beds, with a progressive school of nursing. Postgraduate preparation essential; Baccalaureate Degree preferred.

APPLY TO:
Director of Nursing,
McKELLAR GENERAL HOSPITAL,
Fort William, Ontario.

INSTRUCTOR REQUIRED

Applications are invited for the position of Nursing Instructor for School of Nursing of 30 Students. This position offers an extraordinary opportunity for the right person. Attractive salary and Personnel policies. Preference will be given to male applicants.

Direct inquiries to:
DIRECTOR OF NURSING, VICTORIA HOSPITAL,
Renfrew, Ontario.

ASSISTANT DIRECTOR

Applications are invited for an Assistant Director of the Extension Course in Nursing Unit Administration. This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association.

Qualifications: University preparation in teaching and supervision is necessary with several years experience in a supervisory position.

For further information write to:

Director, Extension Course in Nursing Unit Administration,
CANADIAN HOSPITAL ASSOCIATION,
25 Imperial Street, Toronto 7, Ontario.

CLEARWATER LAKE HOSPITAL
THE PAS, MANITOBA

Requires

1—NIGHT SUPERVISOR	$390-$435
1—HEAD NURSE	$370-$415

Interesting positions in hospital of 150 beds for tuberculosis (Indians and Eskimos) and extended treatment patients. Excellent accommodation in new residence. Enquiries invited.

MISS E. L. M. THORPE, NURSING CONSULTANT,
Sanatorium Board of Manitoba,
800 Sherbrook Street, Winnipeg 2, Manitoba.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GRADUATE STAFF NURSES

EXCELLENT PERSONNEL POLICIES

For further information, write:

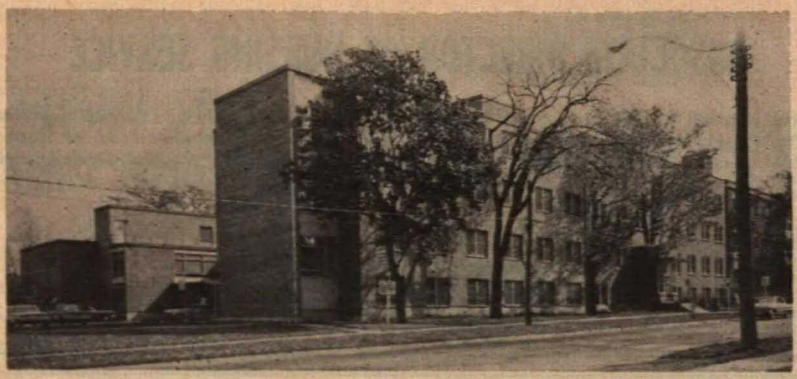
THE DIRECTOR OF NURSING,
Peterborough Civic Hospital, Peterborough, Ontario.

VICTORIA HOSPITAL
London, Ontario

HEAD NURSE for fifty-bed (50) Psychiatric Unit. Duties to commence immediately. Diploma in Nursing Service Administration and postgraduate experience in psychiatric nursing preferred. Salary commensurate with qualifications and experience.

Apply:

DIRECTOR OF NURSING
Victoria Hospital, London, Ontario



ASSISTANT DIRECTOR OF NURSING (EDUCATION)

Required for 75-student School of Nursing in this 250-bed accredited hospital in the Seaway Valley. University preparation required. Good personnel policies including four weeks' vacation, nine statutory holidays, pension plan, group insurance, etc.

Apply to:

ADMINISTRATOR,
CORNWALL GENERAL HOSPITAL, CORNWALL, ONTARIO.

VICTORIA HOSPITAL

LONDON, ONTARIO

Modern 1000-bed hospital

requires

Registered Nurses for all services

and

Registered Nursing Assistants

40 hour week - Pension plan
Good salaries and Personnel Policies.

Apply:

DIRECTOR OF NURSING,
VICTORIA HOSPITAL, LONDON, ONT.

DIRECTOR OF NURSING SERVICE

for the

St. Boniface General Hospital, (715 beds)

University Degree, preferably Master's and experience at an advanced level required.

Please apply, stating full particulars, to:

Personnel Director,
ST. BONIFACE GENERAL HOSPITAL,
St. Boniface, Manitoba.

ASSOCIATE DIRECTOR OF NURSING SERVICE

General Hospital of 280 beds located in a progressive and friendly city in sunny southern Alberta. Population 27,000. School of Nursing with a maximum enrollment of 90 Students. Excellent personnel policies including coverage for hospitalization, medical services and a pension plan. Salary based on education and experience.

Write to:

Director of Nursing,
MEDICINE HAT GENERAL HOSPITAL,
Medicine Hat, Alberta.

GLENROSE PROVINCIAL GENERAL HOSPITAL

requires

SUPERVISOR and STAFF NURSES

FOR HANDICAPPED CHILDREN'S 30-40 BED DEPARTMENT

Also Graduate and Staff Nurses for Convalescent Units approx. 250-300 beds.

Apply in writing:

THE DIRECTOR OF NURSING SERVICE,
Glenrose Provincial General Hospital, 10230-111th Avenue,
Edmonton, Alberta.

NOTRE DAME HOSPITAL

North Battleford, Saskatchewan

REQUIRES

General Staff Nurses and Certified Nursing Assistants for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary range: R.N. $300 to $375, C.N.A. $205 to $235 gross per month. Differential for evening and night duty for R.N.'s. Accommodation close to hospital if desired

Apply to:

DIRECTOR OF NURSING SERVICE,
Notre Dame Hospital, North Battleford, Sask.

ASSISTANT DIRECTOR OF NURSING

REQUIRED

FOR A 163-BED GENERAL HOSPITAL

Pease reply to:

Director of Nursing,
KIRKLAND AND DISTRICT HOSPITAL,
Kirkland Lake, Ontario.

GENERAL STAFF NURSE POSITIONS

AVAILABLE

In the General Operating Rooms (includes general surgery, cardiac, neurosurgery, plastic, ear, nose and throat and urology), Gynecological and Ophthalmological operating rooms. Salary commensurate with experience. Opportunities for promotion. Excellent fringe benefits including refund of tuition up to six points per semester.

For further information write:

Director, Nursing Service,
THE JOHN'S HOPKINS HOSPITAL
Baltimore 5, Maryland.

NURSES

KENORA, ONTARIO

This resort town of 14,000 people has just opened a section of its new 100-bed hospital and in the not too distant future will be opening the second section for which nurses are needed. The hospital is wonderfully located on the shores of beautiful Lake of the Woods in Ontario. In the summer we have activities in swimming, boating, fishing and golfing and in the winter there is skating, curling, tobogganing, skiing and ice fishing.

A nurse's residence is available at a reasonable rate of $20 per month for private room or $15 per month for a double room. Cafeteria services are available at cost as well as a kitchen in the nurses' residence. Separate personnel policies for nurses are available and will be mailed on request. The starting salary is $330 per month. Eight statutory holidays, sick leave, three weeks vacation with pay are some of the benefits of these policies.

All applications will be treated with courtesy and privacy.

Please apply to:

Administrator,
Mr. A. C. DUNCAN,
KENORA GENERAL HOSPITAL,
Kenora, Ontario.

SOUTH PEEL HOSPITAL

COOKSVILLE

A new 450-bed General Hospital, located 12 miles from the City of Toronto, has openings for:

(1) Supervisor for Nursing Office with Nursing Service Administration Diploma.

(2) Supervisor for Unit Administration on Medical Ward.

(3) Head Nurses and Assistant Head Nurses for Medical and Surgical units.

(4) General Staff Nurses in all departments.

Good personnel policies. Salary commensurate with experience and preparation.

For information or application, write to:

DIRECTOR OF NURSING
South Peel Hospital,
Cooksville, Ontario

OPERATING ROOM SUPERVISOR

With Postgraduate Course in Operating Room Technique and Management. Required for a 375-bed fully accredited General Hospital. Salary based on qualifications and experience. Fringe benefits include hospital and medical coverage, generous sick leave, three weeks' vacation and contributory pension plan.

For further information write:

Director of Nursing Service,
METROPOLITAN GENERAL HOSPITAL,
Windsor, Ontario.

OSHAWA GENERAL HOSPITAL

Oshawa, Ontario

Requires for School of Nursing

CLINICAL INSTRUCTOR IN SURGICAL NURSING

with Certificate in Nursing Education

For further information, apply to:

DIRECTOR OF NURSING,
Oshawa General Hospital, Oshawa, Ontario.

GENERAL DUTY NURSES

SALARY RANGE $327 - $362

Required by Metropolitan Toronto for the new Riverdale Hospital, an 800-bed hospital for chronic and convalescent patients. Shift allowances for afternoon and night shifts. Cumulative sick pay and pension plans are in effect. Permanent positions, 40 hour week.

Apply:

PERSONNEL OFFICE,
387 Bloor Street East, Toronto 5, Ontario.

UNIVERSITY HOSPITAL

Saskatoon, Saskatchewan

APPLICATIONS ARE INVITED FOR:
General Staff positions.

OPPORTUNITIES FOR EMPLOYMENT ARE AVAILABLE IN:
Medical, Surgical, Obstetrical, Pediatric, Psychiatric and Rehabilitation Services.

SALARY RANGE:
$300-$360 — Differential for evening and night duty — 40-hour week.

RESIDENCE:
Temporary accommodation if desired.

Apply to:

DIRECTOR OF PERSONNEL, UNIVERSITY HOSPITAL,
Saskatoon, Saskatchewan.

DIRECTOR, SCHOOL OF NURSING

For three year diploma school. Maximum enrollment of 90 students. School is a part of a busy General Hospital of 280 beds in a progressive friendly city located in sunny southern Alberta. Population approximately 27,000. Position created by a change in organization pattern establishing separate administrations for education and service. Excellent personnel policies including a pension plan. Salary based on education and experience.

Write to:

The Administrator,
MEDICINE HAT GENERAL HOSPITAL,
Medicine Hat, Alberta.

ST. JOSEPH'S HOSPITAL

Hamilton, Ontario

A modern, progressive, 850-bed hospital, located in the centre of Ontario's Golden Horseshoe, has openings for:

1) **Head Nurses for Medical or Surgical units.**

   Postgraduate study preferred.

2) **General Staff Nurses in all clinical areas.**

3) **Registered Nursing Assistants in all clinical areas.**

For further information write to:

THE DIRECTOR OF NURSING,
St. Joseph's Hospital,
Hamilton, Ontario.

REGISTERED NURSES

and

REGISTERED NURSING ASSISTANTS

required for

FIVE SUMMER CAMPS

STRATEGICALLY LOCATED
THROUGHOUT ONTARIO
AND NEAR
OTTAWA - LONDON
COLLINGWOOD
PORT COLBORNE
KIRKLAND LAKE

PREFERENCE GIVEN TO APPLICANTS WITH PEDIATRIC EXPERIENCE.

Apply in writing to:

MISS HELEN WALLACE, REG'D.N.
Supervisor of Camps
ONTARIO SOCIETY FOR CRIPPLED CHILDREN
350 Rumsey Road
P.O. Box 1700, Station "R"
Toronto 17, Ontario.

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

360-bed accredited General Hospital. Registered Nurses salary range $315-$355 per month with consideration for contemporary experience or special preparation.

Certified Nursing Assistants $210 - $240 per month.

For further information write:

Director of Nursing Service
METROPOLITAN GENERAL HOSPITAL
Windsor, Ontario.

PORT COLBORNE GENERAL HOSPITAL

PORT COLBORNE, ONTARIO

requires

REGISTERED NURSES

For recently expanded General Hospital, of 166 beds, within easy driving distance of American and Canadian metropolitan centres. Salary $325 per month subject to adjustment review by Jan., 1964. Vacancies in the O.R. and medical and surgical wards.

Apply:

Director of Nursing,
PORT COLBORNE GENERAL HOSPITAL,
Port Colborne, Ontario.

GRADUATE STAFF NURSES

Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room, and emergency room. Well planned orientation and in-service programs, tuition-free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premium for evening and night tours of duty. Starting rate based on experience and education. Staff nurse salary range $385 to $425. Write for more information and the booklet "New Horizons in Nursing," to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITALS OF CLEVELAND,
University Circle, Cleveland 6, Ohio.

MEDICAL SUPERVISOR

POSITION OPEN AT
UNIVERSITY HOSPITAL
Saskatoon, Saskatchewan

POSITION OFFERS THE OPPORTUNITY TO:

1. Supervise in an active medical department.
2. Contribute to University and Diploma nursing student program.
3. Contribute to patient care as part of the medical team.

QUALIFICATIONS:

1. Experience in medical nursing.
2. Preparation and experience in supervision.

Apply to:
DIRECTOR OF PERSONNEL, UNIVERSITY HOSPITAL,
Saskatoon, Saskatchewan.

VICTORIAN ORDER OF NURSES FOR CANADA

OFFERS

Interesting and Challenging Careers. Positions are available in various parts of Canada at prevailing salary rates. Good personnel policies. Pension plan. Transportation on duty. Uniform allowance.

Bursaries are offered to assist students in the final year of the basic degree course or graduate nurses taking preparation in public health nursing.

For further information write:
MISS JEAN LEASK, DIRECTOR IN CHIEF,
5 Blackburn Avenue, Ottawa 2, Ontario.

SCHOOL OF NURSING

METROPOLITAN GENERAL HOSPITAL

requires

INSTRUCTOR IN PSYCHIATRIC NURSING

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experience for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Instruction in Introductory Psychology and Mental Hygiene. Clinical and Classroom Instruction in Psychiatric Nursing. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August, 1964.

For further information, contact:
Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario

YEAR-ROUND SPORTS

Are available at the Lakehead. The McKellar General Hospital and the City of Fort William, provide a friendly, pleasant atmosphere for work and play. Registered Nurses are invited to apply. Cost of transportation here will be prepaid for those staying one year. Basic salary: $325 for nurses registered in Ontario. Good residence accommodation, $30 per month.

For further information, write to:

DIRECTOR OF NURSING,
McKellar General Hospital,
Fort William, Ontario.

CAMP DIRECTORS

Registered Nurses to direct summer camps for crippled children — June, July, August. Preference given to applicants with supervisory experience.

For further information, apply to:

SUPERVISOR OF CAMPS,
Ontario Society for Crippled Children,
Box 1700, Postal Station "R",
350 Rumsey Road, Toronto 17,
Ontario.

SUDBURY MEMORIAL HOSPITAL

Requires

SUPERVISOR FOR NURSING OFFICE

Responsible for In-service program for Non-Professional Staff.

Apply:

DIRECTOR OF NURSING,
Sudbury Memorial Hospital,
Regent Street, S. Sudbury, Ontario.

INSTRUCTORS

for

SCIENCE
SURGICAL-CLINICAL

University preparation required
Salary differential for degree

For further information apply to:

DIRECTOR OF NURSING,
BRANDON GENERAL HOSPITAL,
Brandon, Manitoba.

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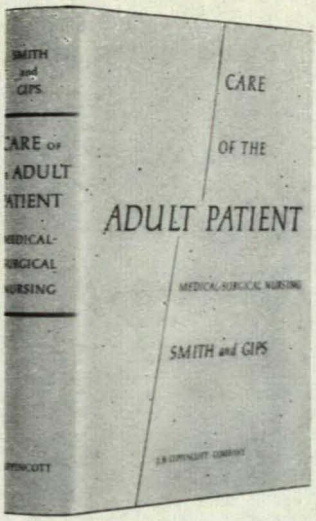

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